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36 Van Natta ___ (1984)

BLANDYNA FOSTER, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 84-0030M
July 3, 1984
Own Motion Order

Claimant requests that the Board exercise its own motion authority and order payment of her medical expenses pursuant to ORS 656.278. Claimant's injury occurred in 1957, before the enactment of the present Workers' Compensation Law and ORS 656.245. Therefore, claimant's medical services are properly before the Board pursuant to ORS 656.278. See William A. Newell, 35 Van Natta 629 (1983). The SAIF Corporation has refused to voluntarily pay claimant's compensation, ORS 656.278(4), and has advised that it is opposed to claimant's request for own motion relief "as it does not appear that the current treatment is other than palliative."

Claimant sustained an apparently severe injury to the fingers of her right hand on May 8, 1957 when it was caught in a laundry press. She sustained a deep burn of the dorsum of all fingers, and a superficial burn on the dorsum of the right forearm and mid portion of the right arm. Claimant had a previous medical history of eczema of both hands in 1949, which had been treated and cleared. During claimant's post-injury convalescence, complications developed and, among other things, claimant experienced an eczematoid reaction of the skin of the burned fingers. In May of 1958 surgery was performed for excision of scar tissue and skin grafting on the dorsum of the middle three fingers of the right hand. Claimant continued to experience dermatitis in the area of the skin graft.

A report of medical examination by Dr. Reeves, dated June 9, 1959, indicates that claimant had "a very aggravating dermatitis" that kept "flaring up." Dr. Reeves' opinion was that this condition would continue to do so for an indefinite period of time. He stated: "It might be well for the [State Industrial Accident] Commission to consider the fact that inasmuch as she will have exacerbations and remissions in the future some arrangement to compensate her for medication, etc., be set up, perhaps much like compensation for continued urethra dilatation after a person has a ruptured urethra."

A document titled "Impression" dated September 22, 1959, indicates that an evidentiary hearing was conducted in connection with claimant's industrial injury. This document apparently contains a statement of a Referee's "impression" of the evidence presented, although no relief was ordered, apparently because the parties were attempting to compromise the claim. A portion of the document states, "All in all this claim represents a very definite and complex problem in that the concluding medical in the file shows that the woman will no doubt require treatment for an indefinite period of time."

On March 19, 1960, the Circuit Court for Baker County entered a Stipulated Judgment Order which awarded claimant additional permanent disability for partial loss of her right ring, middle and index fingers. This Stipulated Order also provides:

> "[I]t is further understood as part of the Stipulation that plaintiff shall be furnished with such further continued medical care and treatment as may appear to

> be necessary to care for the results of the burns sustained in the accident of May 8, 1957 . . . . "

The court remanded to the Commission for an award of compensation in accordance with the terms of the Stipulated Judgment Order. An order was entered accordingly by the Commission, including the provision for "further continued medical care and treatment."

SIAC (which later became the State Compensation Department, then SAIF and finally the SAIF Corporation) continued payment of claimant's medical expenses for treatment of eczematoid dermatitis of the skin graft area of her right hand. A July 1971 report to SAIF from claimant's physician, Dr. Service, indicates that claimant's condition would improve at times, but that it was necessary to continue treatment, which consisted of protecting claimant's hands from moisture and household chemicals, application of topical steroid cream and oral medication which included Atarax, Valium, Compazine and Dilantin, depending upon claimant's response to the medication. A June 1977 report from Dr. Service identified a mild erythema of the fingers and some dystrophy of the fingernails. Claimant was advised to continue use of rubber gloves, Lydex Cream and Atarex.

Apparently in late 1982 claimant moved to St. George, Utah and came under the care of Dr. Duke, dermatologist. An August 17, 1983 report from this physician states, "I have been treating a continuous claim of hard dermatitis, currently doing well on topical steroids and nighttime use of Dalmane, a Benzodiazepine derivative. I recommend that the Dalmane be covered as part of her continuing care."

In October of 1983, claimant corresponded with the SAIF Corporation requesting appropriate forms in order to assist her pharmacist (and ostensibly SAIF) in submitting bills for payment. Apparently SAIF subsequently advised claimant that her claim was "under review." A December 12, 1983 handwritten letter from a Mr. Richard Foster indicates that claimant had paid for certain prescriptions, physician billings and a blood test.

SAIF requested a medical opinion from Dr. Girod, an internist, who reviewed claimant's medical file. He concluded that there was a relationship between claimant's industrial injury and the eczema on claimant's skin graft. He explained that the therapy primarily involves use of topical steroids and avoidance of irritating agents. Atarax and other antihistamine preparations have been used in order to treat a presumed allergic component in persons with eczema, explained Dr. Girod. He also stated that, inasmuch as some dermatologists believe that insomnia and restlessness may contribute to the worsening of eczema, it probably was appropriate to continue payment for sedative medications.

Dr. Duke provided a written report dated February 7, 1984, in which he explained that he had been the dermatologist in charge of claimant's care since December of 1982:

> "Her continuing problem is indeed being palliatively treated because of her injury in 1957. She has split thickness grafting

over the right third, long and index fingers, with chronic damage to the posterior nail folds, chronic paronychial infections, and dryness. Her hands are continually red, irritated, and because of the split thickness graft there is some atrophy over the backs of her hands. Because of the necessary exposure of everyone's hands to water, she has a continuing irritant reaction."

Dr. Duke explained that claimant was being treated with water repellant creams and topical corticosteroid creams, and that he foresees this as "an indefinite problem."

Claimant has since returned to Oregon and apparently is presently residing in Ashland.

As a general rule, workers injured before January 1, 1966 do not have the lifetime right to receive injury-related medical services, as do workers injured on and after that date. William A. Newell, supra. It may appear that the Stipulated Judgment Order entered into between claimant and SIAC in 1960, the terms of which were subsequently incorporated into a Commission order, granted claimant the right to continuing medical care and treatment which appeared necessary for treatment of the residua of claimant's industrial injury, thereby extending a benefit to claimant not otherwise available, as a matter of right, to other similarly situated workers injured in 1957. However, we need not attempt to define the precise meaning of the parties' Stipulation, nor do we need to determine the legal effect of the Commission's 1960 order upon this claim for medical services.

There is no serious question concerning the causal connection between claimant's current medical treatment and her original industrial injury. SAIF is opposed to payment of this compensation solely for the reason that the treatment is "palliative." Assuming that all of the treatment presently being rendered is, in fact, palliative, this fact, in and of itself, does not necessarily require the conclusion that this compensation should not be paid pursuant to the provisions of ORS 656.278. See, e.g. Edward Nixon, 35 Van Natta 1177 (1983). As early as two years after claimant's original injury in 1957, the medical opinion was expressed that this dermatitis condition would continue to exacerbate and remit. Since that time, claimant has continuously experienced medical problems associated with eczema over the area of her skin graft. Although treatment may be considered palliative in the sense that it cannot cure the underlying dermatitis condition, when the eczema exacerbates, the treatment presumably results in remission of the symptoms.

Based on all of the facts and circumstances presented herein, including the 1960 Stipulated Judgment Order and Commission order entered pursuant thereto, which establish that there was the expectation of a continuing need for treatment of this apparently chronic medical problem, we conclude that it is appropriate to require SAIF to pay for claimant's injury-related medical treatment pursuant to ORS 656.278.

Under the terms of this order, SAIF is required to reimburse claimant for medical bills previously paid by claimant, including

the cost of prescription medication incurred for treatment of the residua of claimant's injury. SAIF shall continue payment of medical treatment provided by claimant's attending physician, including the cost of reasonable and necessary prescription medication, until further order of the Board.

IT IS SO ORDERED.

ROBERT G. PERKINS, Claimant
Roll & Westmoreland, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-02991
July 3, 1984
Order on Reconsideration

The Board issued its Order on Review herein on December 29, 1983. 35 Van Natta 1857 (1983). The SAIF Corporation thereafter requested reconsideration of the portion of our order relative to claimant's attorney's fee. On January 27, 1984 we abated our Order on Review in order to provide claimant with an opportunity to respond and to allow sufficient time for consideration of SAIF's request. On reconsideration, we decline to modify our prior order as requested by SAIF.

SAIF requested and claimant cross-requested review of the Referee's order raising issues concerning extent of temporary disability, permanent disability, scheduled and unscheduled, penalties and attorney fees. The Board reversed and modified portions of the Referee's order awarding additional compensation for unscheduled disability, stating: "[T]he fee allowed to claimant's attorney out of this increased award should be adjusted accordingly." The Board affirmed the portion of the Referee's order which imposed a penalty and an associated attorney's fee, albeit with some modification of the amount of the penalty.

SAIF requested reconsideration, advising that during the pendency of the proceedings on Board review, the entire disability award ordered by the Referee had been paid to claimant. See generally ORS 656.313(1), (2). SAIF's request for reconsideration states: "An overpayment is thus created." In addition to paying directly to claimant 75% of the additional compensation awarded by the Referee, SAIF paid claimant's attorney 25% of that additional compensation, in accordance with the terms of the attorney fee agreement between claimant and his attorney and the Referee's order allowing claimant's attorney a reasonable fee payable out of claimant's compensation. The relief which SAIF seeks by way of reconsideration is stated as follows:

> "We request an Order on Reconsideration authorizing setting off the overpayment of attorney fees on the award against the obligation for the attorney fees ordered under the penalty provisions, i.e. the $500, and (2) instructing whether or not the balance of the overpaid attorney fees should be repaid by the claimant's attorney or should be treated as an overpayment which may be set off against any future award of permanent partial disability in the event this claim should sometime be reopened."

The penalty-associated attorney's fee was not paid to claimant's

attorney pending Board review. Reed v. Del Chemical, 26 Or App 733, 741 (1976); see also Bahler v. Mail-Well Envelope Co., 60 Or App 90, 93 (1982).

To begin with, SAIF's assertion that an overpayment has been created by payment of compensation erroneously ordered by the Referee is incorrect. ORS 656.313(2); Glenn O. Hall, 35 Van Natta 275 (1983); Harry C. Jordan, 35 Van Natta 282 (1983); see also Sharon F. Webster, 35 Van Natta 1638 (1983). SAIF's payment of claimant's attorney's fee pending Board review of the Referee's order is in accordance with long-standing Board policy. Richard Carlson, 24 Van Natta 2 (1978); Jose Mendoza, 8 Van Natta 97 (1972); Carlos V. Rios, 8 Van Natta 85 (1972); Ivan W. Davidson, 2 Van Natta 106 (1969). The issue, therefore, is once an employer/insurer has paid an attorney's fee ordered payable out of compensation due claimant under the terms of a Referee's order, and the Board subsequently reduces the award which, in turn, results in a reduction in the net fee payable to claimant's attorney, is the "overpaid attorney's fee" subject to recovery; and, if so, what procedure may be utilized in providing an employer/insurer the opportunity for recoupment.

Our prior decisions holding that the insurer is required to pay claimant's attorney's fee pending Board review when the fee is payable out of claimant's compensation, are all based upon a single rationale:

> "The Board concludes that when compensation is ordered paid to a claimant, the sums due do not lose their character and identification as compensation simply because the claimant is obligated to pay a portion of that compensation to an attorney as a fee." Ivan W. Davidson, supra.
>
> "The fact that an attorney has a lien upon a percentage of the compensation payable does not destroy the status of that portion of an award as 'compensation.'" Jose Mendoza, supra, 8 Van Natta at 98.
>
> "The Board concludes and finds that ORS 656.313 compels an employer or the State Accident Insurance Fund to pay the compensation ordered paid by a hearing officer, the board or court, and that the portion of the compensation payable over to the attorney does not lose it identity as compensation." Carlos V. Rios, supra, 8 Van Natta at 86.

We adhere to the rationale expressed in our earlier decisions. Fees payable out of compensation pursuant to ORS 656.386(2) retain their identity as "compensation." The obligation to pay that portion of the compensation to claimant's attorney as and for a reasonable attorney's fee arises by virtue of ORS 656.313(1). Because the fee does not lose its identity as compensation simply by virtue of the attorney's lien thereon, see OAR 438-47-010(5), under ORS 656.313(2) as interpreted by our decision in Glenn O.

Hall, supra, the insurer is not entitled to recover "an overpaid attorney's fee" where the Board on review reduces the compensation awarded by the Referee.

In reaching this conclusion, we have taken into consideration recent Court of Appeals decisions which arguably are relevant to the question before us. In Mobley v. SAIF, 58 Or App 394 (1982), the court held that where the claimant prevailed on Board review on an insurer-initiated request for review as to issues concerning the compensability of his claim, but the Board reduced the attorney's fee awarded by the Referee, the Board should have awarded claimant's attorney a reasonable attorney's fee for services rendered on Board review, pursuant to ORS 656.382(2).

> "The statute requires the insurer to pay a reasonable attorney's fee if the Board finds that the compensation awarded should not be disallowed or reduced. The Board made such a finding in this case. The reduction in the fee ordered by the Board had no effect on the entitlement to an award of attorney fees under ORS 656.382(2)." 58 Or App at 397.

See also Bahler v. Mail-Well Envelope Co., 60 Or App 90 (1982); Teel v. Weyerhaeuser Co., 58 Or App 564 (1982), rev'd on other grounds, 294 Or 588 (1983) (claimant's attorney entitled to a fee for services on Board review, pursuant to ORS 656.382(2), where claimant prevails on the issue of compensation and the Board reduces or eliminates a penalty imposed by the Referee).

These cases, particularly Mobley, quite clearly stand for the proposition that insurer paid attorney fees awarded in addition to a claimant's compensation are not considered "compensation", at least for purposes of determining an attorney's entitlement to a fee on Board review pursuant to ORS 656.382(2).

The dissent of Board Member Barnes fails to distinguish between attorney fees paid out of claimant's compensation and attorney fees ordered paid by the insurer. Attorney fees paid out of claimant's compensation are analogous to fees paid by any client to his attorney. In addition to their compensatory purpose, insurer paid attorney fees, are intended to act as a deterrent against harrassing or wearing down a claimant. We believe this distinction is inherent in the separate statutory provisions giving rise to the two distinct sources of attorney fees. Teel v. Weyerhaeuser Co., supra, 294 Or at 591; Bracke v. Baza'r, 294 Or 483 (1983). Compare ORS 656.382(2) and 656.386(1) with ORS 656.386(2). Because of this distinction, we consider the above-referenced Court of Appeals decisions of limited value in deciding the issue presently before us.

SAIF's request for an order allowing it to offset the fee paid out of claimant's compensation and designated as the "overpaid fee," against the $500 insurer-paid fee awarded by the Referee pursuant to ORS 656.382(1) and affirmed by the Board, is necessarily based upon the premise that SAIF is entitled to recover this "overpaid fee," and is, in effect, a suggested manner for recovery of a portion of the "overpaid fee." In view of our holding that SAIF is not entitled to recover the "overpaid fee" as a substantive matter, it is unnecessary to address the merits of

this suggested offset procedure.

Claimant's attorney has requested that he be awarded an insurer-paid fee for services rendered in response to SAIF's request for reconsideration. The only question on reconsideration is whether SAIF is able to recover the "overpaid attorney's fee" or a portion thereof. Claimant's attorney is not entitled to an additional fee. See Van DerZanden v. SAIF, 60 Or App 316, 321 (1982); Korter v. EBI Companies, Inc., 46 Or App 43, 54 (1980); cf. SAIF v. Peoples, 59 Or App 593 (1982).

ORDER

On reconsideration of the Order on Review dated December 29, 1983, we adhere to our prior order, which hereby is reaffirmed and republished.

Board Member Barnes, dissenting:

The Board majority holds that when a Referee grants a claimant increased compensation and allows the claimant's attorney a percentage of that increased compensation as a fee:

(1) The attorney fee must be paid pending Board review because ORS 656.313 requires that "compensation" be paid pending Board review and an attorney's fee allowed from a claimant's increased compensation is itself a form of compensation;

(2) If the Board reduces the compensation the Referee awarded to the claimant, which necessarily means that the claimant's attorney's percentage of the increased compensation as a fee should be less, but the employer/insurer has paid out the entire attorney fee pursuant to the Referee's order pending Board review, the claimant's attorney is entitled to retain this windfall and the employer/insurer has absolutely no means available to recover the excess attorney fee paid pending the Board's decision on review.

Since the ultimate issue here presented involves interpretation and application of ORS 656.313, I assume the Board majority finds that the legislature intended these results. In my opinion, it is ludicrous to even suggest that the legislature could have possibly intended such absurd results.

ORS 656.313(1) provides: "Filing by an employer or the insurer of a request for [Board] review or court appeal shall not stay payment of compensation to a claimant." (Emphasis added.)

ORS 656.313(2) provides: "If the board or court subsequently determines that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal." (Emphasis added.)

What could be clearer? Compensation must be paid "to a claimant" pending appeal, and "the claimant" need not repay compensation determined at the appellate level to have been erroneously awarded. The obvious legislative intent to provide

injured workers with a means of support simply leaps from the pages of the Oregon Revised Statutes. See Wisherd v. Paul Koch Volkswagen, 28 Or App 513, 517 (1977). Yet the Board majority now amends ORS 656.313(1) and (2) to say something the legislature never said: That attorney fees must be paid to the claimant's attorney pending appeal, and the attorney need not repay attorney fees determined at the appellate level to have been erroneously awarded. What possible reasoning could have prompted the legislature to extend the same means-of-support protection afforded to claimants to their attorneys?

I acknowledge that prior Board decisions are inconsistent with what I find to be the plain meaning of ORS 656.313. I submit, however, that those prior Board decisions are inconsistent with the rationale of Mobley v. SAIF, 58 Or App 394 (1982). In that case, the Referee had awarded an insurer-paid attorney fee to claimant's attorney. The Board reduced the amount of the insurer-paid attorney fee and found that claimant's attorney was not entitled to an award of an attorney fee at the Board level pursuant to ORS 656.382(2). That statute requires that, when an employer/insurer requests review and we do not reduce "compensation," we must award an employer/insurer-paid attorney fee to the claimant's attorney. We reasoned, in effect, in our Mobley decision that attorney fees are a form of compensation and that, by reducing the Referee's attorney fee award, we had reduced compensation, thus making ORS 656.382(2) inapplicable. The Court of Appeals reversed the Board, holding that our reduction in the amount of Referee-awarded attorney fees was not a reduction in "compensation."

The Board majority here notes the court's decision in Mobley but distinguishes it on the grounds that fees that an employer/insurer pays to a claimant's attorney are not a form of "compensation," except that the fees that an employer/insurer pays to a claimant's attorney are a form of "compensation" when they are expressed as a percentage of the compensation awarded to the claimant. This distinction is specious. There is a single statutory definition of "compensation" -- that stated in ORS 656.005(9). Either all fees for claimant's attorneys come within this statutory definition, or no fees for claimant's attorneys come within this statutory definition. To "reason" that some fees paid claimants' attorneys are "compensation" while other fees paid to claimants' attorneys are not "compensation" only indicates the intensity of the majority's desire to rewrite ORS 656.313 and to dodge the Mobley bullet.

I suggest that the rules most consistent with the plain meaning of ORS 656.313 and judicial precedents would be:

(1) When an employer/insurer appeals from a lower decision that increased the claimant's compensation and allowed the claimant's attorney a fee expressed as a percentage of the increased compensation, the employer/insurer need not pay any of the attorney fee pending an appellate decision; rather, the employer/insurer could hold the amount of its periodic payout that would otherwise go to the claimant's attorney in trust pending the outcome on appeal.

(2) If the employer/insurer pays attorney fees to a claimant's attorney pending an appellate decision, and if the

effect of the appellate decision is to create an "overpayment" in the sense that more fees were paid to the attorney than should have been under the ultimate decision, then some means should exist for the employer/insurer to recoup its overpayment of attorney fees. There is no point in my exploring whether this kind of problem would be a question concerning a claim within our jurisdiction or would more properly belong in some other forum in view of the Board majority's decision to extend the windfall protection of ORS 656.313, which the legislature clearly and understandably limited to claimants, to claimants' attorneys.

GUY E. STEPHENSON, Claimant
Evohl Malagon, Claimant's Attorney
Brian Pocock, Defense Attorney
Bullivant, et al., Defense Attorneys

WCB 83-04982 & 83-04984
July 3, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

GAB Business Services ("GAB"), on behalf of Pacific Marine Insurance ("PMI"), requests review of that portion of Referee Foster's order which found that claimant sustained a new injury in September 1982, rather than an aggravation of a prior injury, and thus set aside the denial of GAB/PMI, which was the insurer on the risk in September 1982, of claimant's new injury claim.

Claimant sustained a compensable injury in January 1982 while Crawford and Company was the insurer on the risk. In March 1982 the employer changed insurers and GAB/PMI assumed the risk. In September 1982 claimant was involved in another injurious incident at work.

GAB initially accepted claimant's September incident as a new injury. However, GAB subsequently issued a backup denial, contending that the September incident was an aggravation of claimant's January injury and thus the responsibility of Crawford and Company. Crawford later denied claimant's alternative aggravation claim. Following Crawford's denial, claimant retained an attorney who filed requests for hearings protesting both denials. The request for hearing protesting GAB's denial was filed more than 60 days but less than 180 days after GAB's denial.

At hearing, GAB contended that claimant's request for hearing as to its denial was not timely. The Referee rejected GAB's position, citing Bauman v. SAIF, 295 Or 788 (1983), for the proposition that the time limits stated in ORS 656.319(1) within which a hearing request must be filed on a denial are inapplicable in a case involving a backup denial. We disagree. Since the Referee's order, we concluded in John E. Russell, 36 Van Natta 678 (1984), that all denials, backup or otherwise, are subject to the time limits stated in ORS 656.319(1), and that Bauman does not hold to the contrary.

We must thus reach the question of whether claimant established good cause for his tardy hearing request on GAB's denial. We conclude that he did. This is a responsibility case involving two insurers. We have previously found good cause for a late hearing request in responsibility cases where the claimant was confused by being caught in a "cross-fire" between two

insurance companies. Curtis A. Lowden, 30 Van Natta 642 (1981). We find that doctrine applicable here. Claimant testified to some understandable confusion about which insurer was responsbile for compensation in connection with the September 1982 incident. Claimant also testified that his treating chiropractor told him that Crawford was paying for the claim and that this was properly an aggravation claim against Crawford. This is sufficient, we believe, to establish that claimant had good cause for his late request for hearing to protest GAB's denial.

On the ultimate question of insurer responsibility, Bauman v. SAIF, supra, does come into play because GAB's denial of claimant's new injury claim was a backup denial. GAB argues that the Bauman doctrine should not be applicable in cases involving only insurer/employer responsibility, and not compensability. We have previously resolved this issue adversely to GAB's position. Cleve A. Retchless, 35 Van Natta 1651, 35 Van Natta 1788 (1983). Therefore, GAB's denial was precluded by Bauman. Moreover, aside from the Bauman/Retchless problem, we agree with the Referee that on the merits there is sufficient evidence to show that the September 1982 incident while GAB was on the risk independently contributed to claimant's disability.

ORDER

The Referee's order dated December 9, 1983 is affirmed. Claimant's attorney is awarded $350 for services on Board review, to be paid by GAB Business Services/Pacific Marine Insurance.

GUY E. STEPHENSON, Claimant
Evohl Malagon, Claimant's Attorney
Brian Pocock, Defense Attorney
Bullivant, et al., Defense Attorneys

WCB 83-04982 & 83-04984
July 27, 1984
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated July 3, 1984. Claimant argues that the Board's award of $350 in attorney's fees for services on Board review is inadequate.

On reconsideration, the Board agrees with claimant that the award of attorney's fees in our Order on Review is inadequate. Accordingly, we modify our Order on Review to award claimant's attorney $550 for services on Board review in lieu of the $350 awarded in our Order on Review.

ORDER

The Board's Order on review is modified to award claimant's attorney $550 for services on Board review, payable by GAB Business Services/Pacific Marine Insurance. In all other respects the Board's Order on Review is adhered to and is hereby republished.

WAUNITA M. WALKER, Claimant
Roll, et al., Claimant's Attorneys
Atherly, et al., Defense Attorneys
Brian Pocock, Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-06208 & 83-01830
July 3, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation on behalf of its insured, Murphy Company, requests review of Referee Howell's order which set aside SAIF/Murphy Company's July 6, 1982 partial denial and awarded claimant's attorney a fee of $1100. SAIF/Murphy Company's denial was based, in part, on their contention that any responsibility for claimant's condition after May 1981 rested with Mapleton School District under the last injurious exposure rule. Referee Howell found that the responsibility issue could not now be litigated inasmuch as SAIF/Murphy Company already raised the issue before Referee Daron in a prior proceeding, or in the alternative, SAIF/Murphy Company unreasonably failed to raise the issue before Referee Daron. Referee Howell also considered the possibility that the Board's review of Referee Daron's order would resolve the issue. The issue on review is whether SAIF/Murphy Company is barred from denying responsibility, and if so, whether the attorney fee award is excessive.

The Board reverses the order of the Referee and remands for a hearing on the merits of the denials issued by SAIF on behalf of Murphy Company and on behalf of Mapleton School District. For the remainder of this order, we refer only to the relevant employer.

Claimant suffered a compensable injury while working for the Murphy Company. The claim was closed by Determination Order dated May 29, 1981 which awarded no permanent disability. Claimant later terminated her employment with Murphy Company and started driving buses for Mapleton School District.

In a prior proceeding, claimant requested a hearing on the May 29, 1981 Determination Order, contending entitlement to an award of permanent disability. In July 1981 claimant began seeing Dr. Nash. Murphy Company refused to pay for Dr. Nash's services and associated travel expenses. Claimant supplemented her request for hearing to include the issues of the compensability of Dr. Nash's bills, associated travel expenses, and penalties and attorney fees. After May 1981 claimant did not seek treatment from any doctor except Dr. Nash.

At hearings before Referee Daron on April 12 and June 24, 1982, Murphy Company contended that claimant was not entitled to a permanent disability award and that Dr. Nash's services were not reasonable, necessary or related to claimant's compensable injury. After the parties rested but before written closing arguments were submitted to Referee Daron, however, Murphy Company notified the Referee and claimant by letter dated July 6, 1982 that it was denying responsibility for claimant's condition and any benefits after the May 1981 Determination Order, on the grounds that: (1) claimant suffered no permanent disability from the injury; (2) claimant remained medically stationary; (3) the treatment claimant received since May 1981 was not reasonable, necessary or related to her injury; and (4) any responsibility for claimant's benefits since May 1981 rested with Mapleton School

District under the last injurious exposure rule. Murphy Company made a request for consolidation of the denial issue with the other issues, which Referee Daron refused.

Referee Daron issued his Opinion and Order on December 22, 1981, wherein he awarded permanent disability, found Dr. Nash's services to be compensable, determined when claimant became medically stationary and decided the penalties and attorney fee issue. Referee Daron also stated, "Except insofar as the same subjects presented by SAIF may be a part of the present proceeding, the issues specified by SAIF in the letter of July 6, 1982 will not be considered in this present proceeding." Murphy Company sought Board review and the Board, by Order on Review dated January 24, 1984, affirmed Referee Daron's refusal to consider Murphy Company's belatedly raised denial issue. Waunita M. Walker, 36 Van Natta 44 (1984). The Board also stated, "We do not intend to hold that, by failing to raise this issue at an earlier date, SAIF has waived this defense entirely; nor do we intend to hold to the contrary." 36 Van Natta at 47.

In the meantime, Mapleton School District denied responsibility. Claimant requested a hearing on Mapleton School District's denial and on Murphy Company's denial, which resulted in a hearing before Referee Howell. At that hearing, claimant and Mapleton School District moved to set aside Murphy Company's denial on the grounds that all issues raised in the denial were decided or could have been decided at the prior hearing and, therefore, were barred by res judicata.

Referee Howell set aside the denial, holding that the first three bases for the denial were specifically decided by Referee Daron and could not be collaterally attacked in the present proceeding. Regarding the fourth basis for the denial, as discussed above Referee Howell stated that Referee Daron possibly considered the question of responsibility or Murphy Company unreasonably failed to timely raise the issue before Referee Daron. Referee Howell also speculated that Referee Daron should have considered the issue. Accordingly, Referee Howell held that either Murphy Company was barred from raising the responsibility defense or the Board's order would resolve the question. Claimant's request for hearing on Mapleton School District's denial was put in inactive status pending resolution of Referee Howell's order.

First, as mentioned above, the Board's Order on Review of Referee Daron's order did not resolve the question of whether Murphy Company would be barred from litigating the responsibility issue at a later time. Second, we disagree with Referee Howell's finding that Referee Daron possibly considered the responsibility issue raised in Murphy Company's denial. Referee Daron specifically refused to consider the new issues raised in Murphy Company's belated denial.

Furthermore, we cannot agree that Murphy Company unreasonably failed to timely raise the responsibility issue before Referee Daron and is, therefore, barred from partially denying responsibility for claimant's condition. This was not a situation where the issues properly raised before Referee Daron included a denial by Murphy Company, who then belatedly attempted to raise an

additional theory for its denial. Million v. SAIF, 45 Or App 1097 (1980); Robert C. Butson, 35 Van Natta 1354 (1983). In addition, the issue Murphy Company now seeks to raise through its denial is not identical to or necessarily included in the issues determined at the first hearing. Farmers Ins. v. Hopson, 53 Or App 109 (1981). Although Murphy Company denied that claimant was permanently disabled from her injury and contended that Dr. Nash's services were not compensable, we find that Murphy Company did not thereby deny responsibility for claimant's condition. Had Murphy Company denied responsibility for claimant's condition prior to the hearings before Referee Daron, or had we been able to find that the issues properly raised before Referee Daron constituted a denial of continuing responsibility, we would hold under Million, supra, that Murphy Company is now barred by res judicata from raising another theory to support its denial, because it could have raised that theory at the first hearing.

Nevertheless, we are troubled by Murphy Company's actions in this matter inasmuch as a proliferation of hearings and appeals has resulted, which we strongly discourage, Elfreda Puckett, 8 Van Natta 158 (1972), and which probably could have been avoided, Walker, 36 Van Natta at 45. Therefore, we have scrutinized the record in an effort to find that Murphy Company's posture going into Referee Daron's hearing constituted a denial, thereby barring Murphy Company from now further litigating that denial. We are almost persuaded that Murphy Company was denying further responsibility for claimant's condition prior to the commencement of the hearings before Referee Daron. First, the reasons listed in the denial overlap with the issues that had already been raised before Referee Daron. Second, Murphy Company now argues on review: "We have always maintained that the question of the Mapleton School District's responsibility was part and parcel of our case and should have been ruled on in the proceedings conducted in front of Referee Daron." App Br at 2.

We find, however, that Murphy Company did not deny responsibility by way of the issues properly raised before Referee Daron. Murphy Company contended at the hearing before Referee Daron that Dr. Nash's treatment was not related to claimant's compensable injury, but that contention falls short of asserting that claimant's condition was not related to her injury. Although claimant's only medical treatment after the May 1981 Determination Order was with Dr. Nash, we do not find a denial of Dr. Nash's services to constitute a denial of continuing responsibility for claimant's condition under these circumstances. The record shows that Murphy Company denied Dr. Nash's bills primarily because it disputed Dr. Nash's examination findings. Moreover, Murphy Company's attorney asked Dr. Degge at the first hearing whether something else could have occurred to produce claimant's complaints. But merely questioning a witness about a fact which could later support a denial also falls short of denying responsibility for claimant's ongoing condition.

Therefore, we find that the July 6, 1982 partial denial was not an issue that could have been alleged in the prior hearing such that Murphy Company is now barred by res judicata from issuing a partial denial. Million v. SAIF, supra; Farmers Ins. v. Hopson, supra; James R. Kunst, 36 Van Natta 861 (June 19, 1984) (where the Board held that an insurer was not barred by

res judicata from denying a claim even though the insurer did not deny the claim at a prior hearing on unilateral termination of time loss benefits).

In addition, we are unwilling to apply Bauman v. SAIF, 295 Or 788 (1983), to bar the partial denial in which Murphy Company denied responsibility for claimant's condition after May 1981 but did not attempt to deny compensability of the entire claim from the outset. See John E. Russell, 36 Van Natta 678 (April 30, 1984).

Therefore, we hold that Murphy Company is not barred by res judicata or by Bauman from partially denying responsibility for claimant's condition. Of course, the parties are bound by Referee Daron's decisions, as affirmed by the Board, regarding permanent disability, claimant's medically stationary status and the compensability of Dr. Nash's services.

Accordingly, we remand this case to the Hearings Division for a hearing on the merits of Murphy Company's and Mapleton School District's denials. Because of our disposition of the first issue, the attorney fee issue raised by Murphy Company is moot.

ORDER

The Referee's orders dated October 28, 1983 and November 7, 1983 are reversed. This matter is remanded to the Hearings Division for a hearing on the merits of the SAIF Corporation's denials issued on behalf of Murphy Company and Mapleton School District.

RAY ARMSTRONG, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 80-01476
July 5, 1984
Order on Remand (Remanding)

On review of the Board's order dated November 10, 1982, the Court of Appeals reversed the Board's order and remanded the case to the Board with instructions to remand to the Referee for the taking of additional evidence.

Now, therefore, the above-noted Board order is vacated, and this claim is remanded to the Hearings Division for the taking of additional evidence in accordance with the Court of Appeals' opinion in Armstrong v. SAIF Corp., 67 Or App 498 (1984).

IT IS SO ORDERED.

KEVIN BETHEL, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-05399
July 5, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Peterson's order which directed SAIF to pay for claimant's chiropractic treatments in excess of the four per month guideline in the Department's rules, and which assessed a penalty. SAIF argues that: (1) the Board lacks jurisdiction; (2) claimant did not establish justification for treatments in excess of four per month; and (3) no penalty is warranted.

Claimant sustained a compensable shoulder/neck strain in April 1982. That injury was sufficiently minor that claimant was able to continue working. In December 1982 claimant began treating with Dr. Llewellyn, a chiropractor. Over the next five and a half months, Dr. Llewellyn submitted bills to SAIF dated Oanuary 11, 1983, February 24, 1983, March 30, 1983, May 2, 1983 and June 2, 1983.

Dr. Llewellyn's bills reflect that he treated claimant on December 16, 17, 18, 20, 22, 24, 27, 29, and 31, 1982; on January 3, 5, 7, 10, 12, 14, 17, 19, 21, 24, 26 and 31, 1983; on February 2, 4, 7, 9, 11, 14, 16, 18, 21, 23, 25 and 28, 1983; on March 2, 4, 7, 11, 14, 16, 18, 21, 23, 25, 28 and 30, 1983; on April 1, 4, 6, 8, 11, 13, 15, 18, 20, 22, 25, 27 and 29, 1983; and on May 2, 4, 6, 9, 10, 11, 16, 18, 20, 26, 27 and 31, 1983. In summary, these bills are for a total of 71 treatments between the middle of December 1982 and the end of May 1983, at a total cost of about $2300.

Claimant's treatment with Dr. Llewellyn continued into June and July, albeit at a reduced frequency because claimant went on vacation. The parties agree that a noncompensable injury in July superseded SAIF's responsibility; so all that is at issue in this proceeding involves Dr. Llewellyn's services between when he began treating claimant in December 1982 and the superseding injury in July 1983.

In response to Dr. Llewellyn's bills, SAIF made partial payments (apparently on the basis of four treatments per month) and sent the doctor a form entitled "Disputed Pay Voucher" with the part payments. This form requested Dr. Llewellyn to provide a narrative report to SAIF justifying the frequency of his treatment of claimant. Dr. Llewellyn responded by reports dated March 18, 1983 and April 27, 1983. SAIF took no further action after receipt of these reports. Claimant's request for hearing was filed on June 9, 1983.

The Board has previously held that it has jurisdiction over such claims. LLoyd C. Dykstra, 36 Van Natta 26 (1984). However, we note that the Referee's order in this case may go further than we did in Dykstra. The Referee reasoned in part: "The 'Disputed Payment Vouchers' were de facto denials." We disagree with this reasoning. When an employer/insurer receives a claim in the form of a bill for rendered medical services, the employer/insurer is entitled to request information from the medical vendor about the nature of, need for, etc., the medical services in question. The employer/insurer is also entitled to defer action on the medical vendor's bill for a reasonable time pending receipt of such requested information. In no sense can a mere request for additional information be deemed a denial, de facto or otherwise. Further, we regard the Disputed Payment Vouchers in this case to be in the nature of requests for additional information.

However, after Dr. Llewellyn responded by reports dated March 18 and April 27 , we think it was then incumbent upon SAIF to do something more, i.e., either accept the doctor's justification for the frequency of his treatment and thus to pay his bills in full, or to reject the doctor's justification for the frequency of his treatment and thus to deny the unpaid portion of his bills. See

Billy J. Eubanks, 35 Van Natta 131 (1983). It was only when SAIF failed to react in any way to Dr. Llewellyn's submission of the information it requested that the pending claim in the form of partially unpaid bills could be said to be in de facto denied status, and when this Board's jurisdiction under Dykstra could come into play.

On the merits, we affirm the Referee. Dr. Llewellyn's explanations for the frequency of his treatment are hardly overwhelming in the context of this claim, i.e., claimant missed no time from work, claimant did not begin chiropractic treatment until more than seven months post-injury and claimant's "need" for frequent treatment was not great enough to interfere with his summer 1983 vacation. However, Dr. Llewellyn's explanation is all that we have, there being no other medical evidence; and we are not prepared to say that explanation is unpersuasive despite some doubts.

On the penalty issue, we also agree with the Referee's conclusion. As noted above, however, we think the only basis for a penalty is SAIF's failure to react in any way after receipt of the narrative reports it requested from Dr. Llewellyn.

ORDER

The Referee's order dated January 4, 1984 is affirmed. Claimant's attorney is awarded $475 for services on Board review, to be paid by the SAIF Corporation.

ARNOLD C. BLONDELL, Claimant
Flaxel, et al., Claimant's Attorneys
W.D. Bates, Jr., Defense Attorney

WCB 82-04202
July 5, 1984
Order on Reconsideration

The Board entered its Order on Review herein on June 15, 1984. 36 Van Natta 818 (1984). Claimant has requested reconsideration of those portions of the order which failed to award an attorney's fee pursuant to ORS 656.382(2), and which held that the employer is entitled to claim an overpayment.

The reason that claimant's attorney is not entitled to a fee on this employer-initiated proceeding is that the only issue raised by the employer was more in the nature of a penalty issue than a compensation issue, and, in either event, under the terms of our order there is a reduction in the net amount payable to claimant. Claimant contends that because the Referee ordered payment of temporary disability benefits, and the Board "affirmed the Referee's order awarding time loss compensation," he is entitled to an insurer-paid fee for prevailing on the issue of compensation. See Bahler v. Mail-Well Envelope Company, 60 Or App 90 (1982); Teel v. Weyerhaeuser Co., 58 Or App 564 (1982), rev'd on other grounds 294 Or 588 (1983); Mobley v. SAIF, 58 Or App 394 (1982).

The Referee did not "award" claimant the temporary disability in question. The Referee specifically determined that claimant had failed to establish a substantive entitlement to this compensation; however, the Referee ordered the employer to pay claimant this compensation in view of the fact that the Determination Order awarded it and the employer simply failed to comply with the terms of the Determination Order. See OAR 436-54-310(3)(e) (temporary disability benefits must be paid no

later than the fourteenth day after the date of a Determination Order). In fact, the only relief granted by the Referee was in the form of requiring the employer to pay compensation awarded by the Determination Order and, in addition, penalties and attorney fees for the employer's failure to pay and failure to timely pay.

On our review of the Referee's order, we agreed with his determination that claimant failed to establish a substantive entitlement to the temporary disability in issue. We further agreed with the Referee's order requiring that the employer pay the temporary disability; however, we concluded that the employer would be permitted to recover the erroneously awarded temporary disability compensation subject to the procedural requirements of the law. See Forney v. Western States Plywood, 66 Or App 155 (1983).

Under these circumstances, our order does not constitute a finding that "the compensation awarded to a claimant should not be disallowed or reduced," a prerequisite to claimant's entitlement to an employer-paid attorney's fee under the provisions of ORS 656.382(2). We also note that in a portion of his request for reconsideration, claimant apparently concedes that the effect of our order is to reduce claimant's compensation.

With regard to the remaining issue raised by this request for reconsideration, we believe that our Order on Review adequately addresses claimant's contentions.

ORDER

On reconsideration of the Order on Review dated June 15, 1984, the Board adheres to its prior order, which hereby is readopted and republished.

WARREN C. SMITH, Claimant
Robert Dames, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08811
July 5, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Williams' order which set aside its denial of claimant's occupational disease claim for depression accompanied by alcohol abuse. The only issue is compensability. In view of subsequent appellate court decisions, we disagree with the Referee and reverse.

Claimant was 57 years old at the time of hearing. He worked for approximately 10 years as an economist for the State Employment Division.

Claimant started drinking when he was a teenager, and knew by the 1960s that he was addicted to alcohol. However, he enjoyed a successful scholastic and, initially, professional career. Claimant obtained a bachelor's degree in economics as well as bachelor's and master's degrees in business administration. He held responsible and well paying jobs with several large corporations. Eventually, in the late 1960s claimant's drinking began to interfere with his work and he was terminated. From approximately late 1968 until late 1971, between intermittent

bouts of drinking, claimant was in and out of alcohol treatment facilities. Also during this period, his marriage of fifteen years ended in divorce.

Claimant went to work for the State of Oregon in December 1971. He worked in Salem until June 1980. During these many years in Salem, claimant formed friendships, became involved in his church and developed an excellent support system. He was happy with his work and refrained from drinking. During the last two years of his Salem assignment, claimant and a woman who lived in Salem developed a romantic relationship.

In June 1980 claimant's position was transferred to Portland. Claimant testified that this transfer had been discussed for a substantial period of time prior to the actual move. He perceived the move as management's way of disposing of him and his relatively high salary. Claimant also testified that the transfer was not voluntary. Although he was never expressly told so, claimant believed he had to accept the transfer to Portland or risk losing his job.

Claimant's department supervisor testified that there was no plot or management decision to "get rid" of claimant. Nor was the supervisor aware of any coercive tactics that had been used to force claimant to move. He did acknowledge that claimant indicated a "mild preference" to remain in Salem. However, the supervisor also testified that he understood that claimant felt some attraction to the possibility of a transfer to Portland because claimant was interested in possibly applying for the position of supervisor in the Portland office, which would be a promotion for claimant. The supervisor recalled claimant inquiring whether seniority would be a factor in choosing the new Portland supervisor. Following his transfer to Portland, claimant did interview for the Portland supervisor position, but was not chosen.

The supervisor testified that claimant had no valid reason to fear discharge; rather, once claimant's position was transferred to Portland, claimant had the option of objecting to the transfer, filing a grievance, moving to the new job site, commuting to the new job site or resigning.

For the first six weeks following his transfer, claimant commuted from Salem. When commuting proved to be unsatisfactory, claimant purchased a condominium in Lake Oswego. Claimant then bought new furnishings for the condominium. Claimant soon found his financial position untenable because of these relatively large purchases in a relatively short period of time. He eventually filed for bankruptcy.

By the end of the summer of 1980, i.e., about six months after claimant's move to Portland, claimant and his woman friend, who still lived in Salem, mutually agreed to terminate their relationship because of the decreased frequency of their opportunities to be together.

Claimant testified that he felt more vulnerable in his Portland position. He stated he was constantly criticized by his de facto Portland supervisor and was "treated like a child" in the handling of his reports.

Approximately five months after his transfer, claimant began to drink. His performance soon suffered and he was disciplined. From February 1981 until December 1981, claimant was treated at numerous hospitals for his alcohol-related problems. Dr. Anderson, a psychiatrist, met with claimant on three separate occasions in June 1981. In a June 16, 1981 chart note, Dr. Anderson noted that claimant "again" talked about his failed marriage, his alcoholism, his former wife's psychiatric problems, his divorce and how the financial aspects of the divorce were responsible for his continuing financial distress. Dr. Anderson noted that claimant tended to retreat into the past.

During 1981 claimant experienced several stressful personal events. He filed for bankruptcy, was hospitalized for a hypothyroid problem, underwent prostate surgery and was hospitalized for three days following a car accident. Finally, in December 1981, he was deemed to have resigned from his position due to his failure to report for work while on unauthorized leave.

In June 1982 claimant was referred by his family doctor to Dr. Eastman, a psychiatrist, for treatment of depression. Dr. Eastman saw claimant seventeen times between June 1982 and June 1983. Dr. Eastman has opined that claimant's job relocation and his new job environment were the major cause of claimant's psychiatric problems and relapse into alcoholism. The doctor opined that claimant's alcoholism was the primary cause of his problems and his depression was secondary.

On cross examination, Dr. Eastman acknowledged that he was generally unaware of the histories claimant had given to other doctors. He also stated that he and claimant had not discussed much about claimant's prior work experiences or family relationships. Dr. Eastman admitted that he had had no contact with Dr. Anderson, the psychiatrist who treated claimant in June 1981. Dr. Eastman agreed that claimant's mind, by virtue of his alcohol problem, would not place him in the best position to recall and relate his medical history.

Claimant was also examined by Dr. Holland, a psychiatrist. Dr. Holland found claimant's history full of inconsistencies and inaccuracies, which raised the possibility that claimant was "somewhat less than totally committed to candidness." Dr. Holland noted that claimant announced that he had every intention of killing himself when his money ran out. Claimant also lamented that perhaps he did not object as strongly as he should have to the transfer to Portland. Dr. Holland opined that claimant's work activities were not the major cause of his present psychological problems, including alcoholism. However, Dr. Holland concluded that the critical question was "whether or not [claimant] did indeed elect, on his own, to be transferred to Portland or whether this was an event imposed upon him by his employment."

The Referee found Dr. Eastman's analysis persuasive. The Referee found Dr. Holland's analysis unpersuasive, particularly because Dr. Holland used a standard based on an assessment of stress to an average person in similar circumstances. The Referee also expressly found that the sources of stress that would otherwise seem to be personal, such as the termination of a

romantic relationship and bankruptcy, were established to be job related in this case because the genesis of all these problems was claimant's job transfer to Portland.

We disagree with the Referee's analysis and conclusion. Since the Referee issued his order, the Supreme Court has issued its opinion in McGarrah v. SAIF, 296 Or 145 (1983). The McGarrah court found that, in order for a stress-related condition to be compensable as an occupational disease, the on-the-job stressful conditions must actually exist, that is, from an objective standpoint the on-the-job stress must be real as opposed to imaginary. Furthermore, the employment conditions, when compared to non-employment conditions, must be the major cause of the psychiatric illness for which compensation is claimed.

Applying McGarrah, it is not disputed that claimant's position was transferred from Salem to Portland; however, we find little or no evidence that, objectively, this was a real source of stress. The preponderance of the evidence indicates that, at most, claimant voiced a mild preference to remain in Salem. Moreover, persuasive evidence indicates that also he viewed the transfer as an opportunity for promotion, as shown by his subsequent application for a supervisory position. Furthermore, claimant did not begin to drink until about five months after the transfer, which was more contemporaneous with the financial burdens of his purchase of a condominium and new furnishings and with the "beginning of the end" of his romantic relationship.

We cannot agree that all of claimant's financial and romantic problems were "caused" by his job transfer in any fair sense of the concept of causation. Those problems were the result of personal decisions that claimant either made or in which claimant participated. Those personal decisions were, admittedly, incidental to claimant's job transfer, but the transfer did not "cause" those decisions to be made in any particular manner.

In addition, we are not as persuaded by Dr. Eastman's opinion as was the Referee. Dr. Eastman relied solely on claimant's history, which the doctor admitted was of debatable reliability under the circumstances. For example, Dr. Eastman did not consider any of the records of Dr. Anderson's prior psychiatric treatment; but we think it is significant that Dr. Anderson's chart notes, which describe claimant's paramount concerns in June 1981, fail to relate claimant's problems to his job or to his transfer.

Our review of the record reveals that the major focus of claimant's problem centers upon his financial situation. From the initial reports to the most recent reports, claimant demonstrates a preoccupation with continuing financial problems. Even Dr. Eastman acknowledged that claimant appeared preoccupied with his finances.

Without question, claimant was subjected to considerable stress. However, a significant portion of that stress was directly and solely attributable to his personal life. A portion of the stress was preexisting from his late 1960s unemployment, divorce and alcoholism treatment bills. Another large portion arose from his bankruptcy, hypothyroid condition, car accident and prostate surgery, all of which occurred in 1981. None of these stressors can be attributed to his employment.

Dr. Holland identified most of these nonoccupational sources of stress and opined that, because of this likely nonoccupational contributing causation, work stress was not the major cause of claimant's psychiatric illness/alcoholism. While Dr. Holland did discuss how various forms of stress would likely affect an average person, we think this is at least some indirect evidence of how various forms of stress likely affected this claimant and, in any event, Dr. Holland's analysis is not too different from the Supreme Court's subsesquent analysis in its McGarrah decision. In the face of this evidence, we do not find Dr. Eastman's contrary opinion persuasive.

For all of these reasons, we conclude that the evidence does not preponderate in favor of a finding that claimant's job transfer and work conditions were the major cause of his current condition.

ORDER

The Referee's order dated September 1, 1983 is reversed. The SAIF Corporation's denial dated August 11, 1982 is reinstated and affirmed.

CLYDE C. WYANT, Claimant
Robert Burns, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07956
July 5, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Podnar's order which overturned its partial denial of claimant's headaches. Claimant cross-requests review of those portions of the Referee's order which refused to award claimant temporary disability benefits for alleged time loss due to the headaches.

The issue of temporary disability is not addressed because of our disposition of the compensability issue.

Claimant compensably injured his low back in June 1976. Claimant has experienced headaches since a myelogram which was performed on July 20, 1976. SAIF has paid for medical treatment since the injury pursuant to ORS 656.245. Some of the medical treatment for which SAIF has paid has included treatment of the headaches.

On May 10, 1982 Dr. Reilly, a neurological consultant for SAIF, reviewed claimant's file and authored a memorandum in which he opined that claimant's headaches are not related to the myelogram. Dr. Stolzberg, a neurologist, examined claimant on July 8, 1982. He opined that claimant's headaches were unrelated to the myelogram and were unrelated to his compensable injury. SAIF issued a partial denial of medical benefits for the headaches on August 3, 1982. On August 16, 1982 Dr. Hill examined claimant and reported to Dr. Richards, the treating doctor, that he was unable to explain claimant's headaches. He said it would be very unusual for a post-myelogram headache to last five years.

The Referee overturned the denial. He stated "The analogies between this matter and the holding in Bauman v. SAIF, 62 Or App 323 (1983), seem patently obvious."

The Supreme Court affirmed the Court of Appeals in Bauman v. SAIF, 295 Or 788 (1983). However, we do not believe that SAIF's partial denial of continuing medical benefits is precluded by Bauman. In Bauman, the insurer had accepted a claim and paid benefits on it for several years. When claimant filed an aggravation claim, the insurer backed up and denied the compensability of the original claim. In this case, SAIF is not attempting to deny the compensability of the original claim. It is merely attempting to deny the compensability of medical services for a condition which it has reason to believe is not causally related to the compensable claim. We do not believe that Bauman precludes partial denials for continuing medical services which the insurer has reason to believe are not causally related to the accepted claim. Accordingly, we find that SAIF is not precluded by Bauman from denying its responsiblity for medical services for claimant's headaches.

On the merits, the evidence is overwhelming that claimant's headaches are unrelated to his compensable injury or its sequalae.

ORDER

The Referee's order dated November 7, 1983 is reversed.

DUANE W. KRUGER, Claimant
Velure & Bruce, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-01690
July 12, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Danner's order which held that the insurer had acted properly in offsetting allegedly overpaid benefits against claimant's current permanent total disability payments.

Claimant received an award for permanent total disability benefits by a Determination Order dated January 22, 1982. Beginning about February 1, 1982, the insurer began making monthly payments toward claimant's permanent total disability award in the amount of $1,247.93. The insurer made eleven monthly payments of that amount. On January 27, 1983 the insurer sent the following letter to claimant:

> "I received notification from the State of Oregon Retro Reimbursement Department that the permanent total disability benefits paid to you have been paid at an incorrect rate.
>
> * * *
>
> "Therefore, your correct permanent total disability rate is $1,073.14 a month. As you know, we have been paying you $1,247.93. This has caused an overpayment of $174.79 per month for the last 11 months for a total of $1,922.69.
>
> "In order to help us recover this overpayment, we will be deducting $73.14 from your check until this overpayment is recovered."

On February 28, 1983 the insurer responded to a Request for Hearing filed by claimant to protest the offset. It noted that it was relying on OAR 436-54-320 as authority allowing it to take an offset.

On May 12, 1983 an auditor for the Workers' Compensation Department's Compliance Division wrote the employer, stating: "You are entitled to recover the overpayment in retroactive benefits. Your recovery of the overpayment, however, should be in amounts that will not create economic burden on the claimant."

The Referee relied on OAR 436-54-320 and held that the insurer acted properly in taking the offset. Since the Referee issued his order, the Court of Appeals has invalidated that portion of the regulation which allows the insurer to take an offset without prior authorization of the Evaluation Division. Forney v. Western States Plywood, 66 Or App 155 (1983). The insurer argues, however, that it acted with the supervision of the Department, so the offset should be upheld as proper.

In Forney, the court referred to its decisions in Wilson v. SAIF, 48 Or App 993 (1980), and Hicks v. Fred Meyer, Inc., 57 Or App 68 (1982), in which it disapproved of unilateral recovery of overpayments. In Wilson, the policy underlying the court's decision was:

> "The desirability of maintaining an orderly compensation process, wherein not only amounts of awards but also any deductions to be made from those awards are established by an appropriate action by the Board or its representative, rather than by the unilateral decision of a workers' compensation carrier." 48 Or App at 997.

There is no indication that the insurer received any kind of authorization for taking an offset prior to the Compliance Division's letter of May 12, 1983. Accordingly, any offset taken prior to that date is invalid. The offsets taken for subsequent months are more troubling. The insurer did have authorization from a division of the Workers' Compensation Department to take an offset. This satisfies the court's concern expressed in Wilson and implied in Forney that an orderly compensation system requires external approval before an insurer may begin deducting an offset. The problem with this type of authorization is that it does not inform claimant that he has a right to contest the offset at a hearing. In a similar context, the Court of Appeals has said that termination of temporary total disability benefits for failure to appear at an independent medical examination may only be undertaken if: (1) the insurer notifies the claimant it has requested authorization to suspend benefits; (2) the insurer gives claimant notice of the basis for suspending those benefits; and (3) the claimant is notified of an opportunity to respond. Carr v. SAIF, 65 Or App 110, 124 (1983). The protected interest in Carr is similar to the protected interest in this case. We find that reduction of benefits in this situation requires steps similar to those outlined by the Carr court. The insurer actually began taking an offset prior to receiving authorization. It informed claimant of the basis for the offset but did not notify claimant he had an opportunity to respond or to contest the

offset. Accordingly, we hold that the insurer improperly reduced claimant's monthly benefits.

ORDER

The Referee's order dated October 20, 1983 is reversed. Claimant's attorney is awarded $650 for services on Board review, payable by the insurer.

WILBUR A. LEWIS, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-09923 & 82-09922
July 12, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Howell's order which ordered it to accept and pay for medical treatment of claimant's neck, upper back and bilateral shoulder condition in connection with claimant's January 5, 1972 accepted industrial injury. Claimant cross-requests review of that portion of the Referee's order which, in effect, determined that claimant's current cervical problems were attributable to claimant's 1972 injury, as opposed to a more recent industrial injury which occurred on December 18, 1978. The issues on review are the compensability of claimant's current cervical condition and, assuming this condition is otherwise compensable, whether SAIF should be required to process the claim under the 1972 injury or, instead, under the 1978 injury claim.

Claimant's aggravation rights have expired with regard to the 1972 claim. By an order dated March 17, 1983, the Board referred claimant's request for own motion relief in connection with the 1972 injury claim to the Hearings Division for consolidation with claimant's pending hearing requests herein. In addition to entering his order pursuant to ORS 656.289, addressing those issues properly before him, including claimant's entitlement to medical services pursuant to ORS 656.245 in connection with the 1972 claim, the Referee made a recommendation to the Board concerning claimant's request for own motion relief. The Board has this day issued a separate order in Own Motion No. 82-0160M addressing the issues arising under ORS 656.278.

On our de novo review of the record, we agree with the Referee's determination concerning the compensability of claimant's current cervical problems, as well as his determination that these problems are attributable to claimant's 1972 injury. Accordingly, we affirm and adopt the Referee's well-reasoned order.

ORDER

The Referee's order dated August 8, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review.

NEIL D. MALONEY, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-11178
July 12, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Baker's order which upheld the SAIF Corporation's partial denial of medical services for weight loss.

Claimant sustained a compensable left leg injury in April of 1977. At that time claimant weighed about 345 pounds. Claimant subsequently reduced his weight to about 225 pounds. Claimant's doctors have applauded this weight loss and noted a corresponding reduction in claimant's leg symptoms and improvement in claimant's leg function. The doctors opine, however, that further weight loss is necessary to reduce claimant's leg symptoms and improve his leg function even more.

Claimant admits that his obesity preexisted his compensable injury and was not caused or worsened by that injury. Claimant nevertheless argues that ORS 656.245 mandates that the workers' compensation system should pay for medical treatment of his obesity. We considered and rejected all of claimant's arguments for that proposition in Mark G. Blanchard, 34 Van Natta 1660 (1982), with one exception.

Claimant argues that the subsequent Supreme Court decision in Nelson v. EBI, 296 Or 246 (1984), is inconsistent with our decision in Blanchard. Claimant reasons that, if it is appropriate to reduce a permanent disability award because of unreasonable failure to follow a weight loss program, which claimant reads Nelson as holding, then it is also appropriate to provide compensation in the form of medical services for weight loss which are needed to reduce the extent of a claimant's disability. The flaw in that reasoning is readily apparent. There are dozens of cases in which it has been found that the claimant's overall physical impairment consists of a compensable component and a noncompensable component. Claimant's position in that kind of situation, carried to its logical conclusion, would be that the workers' compensation system would always have to provide medical treatment for both the compensable and noncompensable problems. That is not what ORS 656.245(1) says; that statute requires only medical treatment "for conditions resulting from the [compensable] injury." (Emphasis added.) Claimant's obesity did not "result from" his compensable leg injury.

ORDER

The Referee's order dated November 23, 1983 is affirmed.

LORETA E. PARKER, Claimant
Green, et al., Claimant's Attorneys
Miller, et al., Defense Attorneys

WCB 83-04072
July 12, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer, Portland Public Schools, requests review of Referee Gemmell's order which set aside its April 11, 1983 denial. The issue for review is whether claimant's March 10, 1983 injury arose out of and in the course of her employment.

The Multiple Sclerosis Society's (MS Society) Read-A-Thon program is a charitable fund-raising program offered to children through the school system. As the Referee explained, the program works as follows:

> "[An MS Society fund raising coordinator] introduces the program to the school systems by attending a meeting of media specialists at the school district and presenting her program to them. The media specialists then have a choice as to whether to make the program and materials available at their schools. The program materials include a film to be shown to the students, a brochure and sponsor list, and registration cards. The students are shown the film and given the materials. It is then up to them to go out and find sponsors who will pledge money for each book that the student reads. The student collects the money and sends it directly to MS. The student returns his registration card to the teacher who mails it to MS. Prizes are awarded by MS. Every participating student receives a certificate, a patch and a coupon for a McDonald's hamburger. Prizes for reading given numbers of books are provided by both McDonald's and MS. The brochure and sponsor list bears the McDonald's logo (and the Alaska Airlines logo) and refers to the prizes supplied by McDonald's."

Portland Public Schools' official policy with respect to the Read-A-Thon program is as follows:

> "Board Policy 320.21 states that the only official school charitable drive is the United Good Neighbors. Therefore, student participation in [the Read-A-Thon program] must be limited to voluntary actions by school staff and students. Activities in these drives must take place outside of instructional time (i.e., lunch hours or after school). Any student meetings must occur during these times and staff participation must be voluntary."

Claimant is employed as a sixth grade school teacher at Sellwood Middle School (Sellwood). Sometime before March 10, 1983, the Read-A-Thon program was presented to claimant and several other teachers at Sellwood. The teachers agreed to present the program to their students.

Near the end of the school day on March 10, 1983, claimant showed the Read-A-Thon film to her students. After viewing the film, claimant realized that she did not have enough brochures and registration cards for her students. Claimant discussed this problem with Ms. Rosenbaum, another teacher. Both claimant and Ms. Rosenbaum assumed that since McDonald's was a sponsor of the program, additional program materials were available at any local McDonald's restaurant. Claimant wanted the materials before the weekend as she felt that her students' enthusiasm was high and they could find sponsors during the weekend. Claimant informed Ms. Rosenbaum that she would stop at a McDonald's and get the materials.

Claimant thereafter went home, mowed her lawn and ate dinner. Claimant decided that it would be more convenient for her to stop at the McDonald's near the Clackamas Town Center as she had some personal business to conduct at a Meier & Frank store located in that shopping mall. Claimant, using her own automobile, then drove to Meier & Frank. After completing her business, claimant drove to a nearby McDonald's and parked in its parking lot. As claimant got out of her car and started walking toward the entrance, she fell and broke her left foot. Despite her injury, claimant went into the restaurant. No one in the restaurant knew anything about the Read-A-Thon program or materials.

Shirley Morgan, Marketing Coordinator for McDonald's, testified at the hearing that the McDonald's Corporation's only involvement with the Read-A-Thon program was that of a sponsor, and that it was the MS Society's responsibility to provide materials and anything else necessary for the program through its own office.

A claim was filed on March 17, 1983, and denied by the employer on April 11, 1983.

Carl Piacentini, Supervising Principal at Sellwood, testified at the hearing. Mr. Piacentini stated that any involvement with the Read-A-Thon program was purely voluntary on the part of the students and their teachers. He testified that claimant neither asked his permission nor informed him that she was going to McDonald's for program materials. Mr. Piacentini stated that permission would not have been granted had it been requested, and that claimant was not paid for her time or mileage. He testified that the employment contract in effect between the teachers and the school only gave the employer the right to require teachers to report to their teaching stations 15 minutes prior to their classes, to remain for 15 mintues after finishing their classes and to attend not more than two evening meetings per year. Mr. Piacentini also stated that the only teachers authorized for after-hours trips were physical education and industrial arts instructors for the purposes of picking up athletic equipment

and/or supplies for shop classes, etc. Mileage is paid for such authorized trips.

Based on Rogers v. SAIF, 289 Or 633 (1980), and Jordan v. Western Electric, 1 Or App 441 (1970), the Referee concluded that the claim was compensable. We disagree.

The court in Rogers v. SAIF, supra, adopted the unitary "work-connection" approach to questions involving course and scope of employment. This test sets forth the ultimate inquiry as being: "Is the relationship between the injury and the employment sufficient that the injury should be compensable?" 289 Or at 642. However, there exists no definite formula which can be relied on to determine whether an employe has been injured in the course of employment in any given case. Hansen v. SAIF, 28 Or App 263, 265 (1977).

The Referee applied the tests set forth in Jordan v. Western Electric, supra, for resolving questions involving course of employment and found that all but two of the Jordan factors were satisfied in this case; claimant was not paid for her trip to McDonald's and the activity did not occur on the employer's premises. Unlike the Referee, we find that virtually none of the Jordan criteria have been satisfied in this case.

We agree with the Referee that claimant's injury clearly did not occur on her employer's premises, and there is no question that she was not paid for her time or mileage. However, we do not find that the employer directed or acquiesced in the activity. The claimant did not request permission for her trip to McDonald's or inform her employer about it, and there is no "past practice" relative to such trips from which acquiescence could be inferred. The evidence is also convincing that claimant's activity was not contemplated by her employer. Although permitted by the employer, the Read-A-Thon program was purely voluntary in nature. In fact, the employer posted a memorandum setting forth this official policy on the school bulletin board. Additionally, there was a personal element to claimant's trip as she was transacting some private business at Meier & Frank before going to McDonald's. Thus, we find that claimant has satisfied virtually none of the tests set forth in Jordan v. Western Electric, supra.

Although the relationship is not perfect, this case appears similar to the dual purpose trip rule set forth in Gumbrecht v. SAIF, 21 Or App 389, 392-93 (1975). The dual purpose trip rule is, in turn, one of the many subsidiaries of the going and coming rule, which states that injures sustained by employes when going to and coming from their regular place of work are not injuries which arise out of and in the course of employment. Gumbrecht v. SAIF, supra, 21 Or App at 392.

The dual purpose trip rule, however, does not aid claimant because claimant's trip to McDonald's did not arise out of claimant's employment. Claimant was not instructed by her employer to make a trip to McDonald's, and she never requested permission to do so. Nor was claimant required by her employment to make such a trip. In other cases involving dual purpose trips, there was at least some express or implied authorization by the employer for the trip, or at least some contention that there was some type of control exercised by the employer. Gumbrecht v. SAIF,

supra; Rosencrantz v. Insurance Service, 2 Or App 225 (1970); James A. Taylor, 29 Van Natta 847 (1980). All these elements are missing in the current case.

Since one of the benefits of the Read-A-Thon program was to encourage reading, and since education was the employer's "business," the Referee found claimant's activity to have been beneficial to the employer. In its brief to the Referee, the employer concedes that had claimant's trip been authorized or required by the employer, claimant's injury would be compensable. Similarly, if claimant had been an industrial arts instructor injured while picking up class materials, the employer agrees that such a claim would also be compensable. However, the employer argues that in cases where an employe is performing several personal errands and is injured while also performing some act which better enables him or her to perform his employment duties, the injury is not compensable. The employer states:

> "This could be virtually anything from picking up a specific book that the teacher feels would be interesting to his/her class, taking photographs while on vacation with the thought of showing them to his/her class when he/she returns, or even the cutting out of pictures from a magazine at home with the intent of making a collage, etc."

The employer refers to such situations as the "little trip doctrine" and argues that injuries which occur during the course of such trips or activities are not compensable. We agree. The fact that an employe, during his off-duty hours, may be performing some act which better enables him to function as an employe or enhances his value as an employe is not sufficient by itself to make an injury occurring during the course of such activity compensable. See Haugen v. SAIF, 37 Or App 601 (1978). Although it is true that there may have been some peripheral benefit to the employer by claimant's stop at McDonald's, we find that this action by claimant was performed more out of her professional interests than any intent to benefit the employer.

Based on all the above, we conclude that claimant did not sustain any injury which arose out of and in the course of her employment.

ORDER

The Referee's order dated December 14, 1983 is reversed. The employer's denial dated April 11, 1983 is reinstated and affirmed.

CHARLES D. CAMPBELL, Claimant
David Force, Claimant's Attorney
A.J. Morris, Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03564
July 16, 1984
Order on Reconsideration

On May 23, 1984 the Board abated its Order on Review dated April 25, 1984, so that claimant's attorney would have sufficient time to review the order and advise his client. Claimant's attorney originally did not receive a copy of the Board's Order on Review.

Having given claimant's attorney sufficient time to review the order and claimant's attorney having notified the Board that he does not wish to request reconsideration by the Board, the Board hereby republishes its order dated April 25, 1984. Appeal rights begin to run as of the date of this order.

IT IS SO ORDERED.

JOSE LOPEZ BRICENO, Claimant
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01697 & 83-01982
July 16, 1984
Order Denying Request to Dismiss

The Board has received respondent, Northwest Farm Bureau's motion to dismiss claimant's request for Board review on the grounds claimant has not filed an appellant's brief.

There is no requirement in the workers' compensation law or the Board rules that a brief must be filed by appellant or respondent before the Board will review the case. ORS 656.295(5). While briefs are a significant aid in the review process, failure to file a brief is not grounds for dismissal of a request for review. The request for dismissal hereby is denied.

The respondent, Northwest Farm Bureau, is granted 20 days from the date of this order in which to file its respondents brief.

IT IS SO ORDERED.

RONALD W. MOGLIOTTI, Claimant
Dennis H. Henninger, Claimant's Attorney
Keith D. Skelton, Defense Attorney

WCB 81-10963
July 16, 1984
Order on Reconsideration

Claimant requests review of our Order on Remand in this case, dated June 18, 1984 which denied his motion for an award of additional attorney's fees.

We have no authority to award an additional attorney fee over that awarded by the court unless ordered to do so by court order. For that reason, we adhere to our June 18, 1984 order.

IT IS SO ORDERED.

TILLMAN E. PRICE, Claimant
David Blunt, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-00575
July 16, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Peterson's order which set aside its January 5, 1983 aggravation claim denial, admitted the January 12, 1983 report of Dr. White over SAIF's objection that the report was submitted in violation of the ten day rule contained in OAR 436-83-400(3), and assessed a 25% penalty against SAIF for unreasonable denial. SAIF contends that the Referee erred on all counts.

We adopt the Referee's findings of fact as our own.

With regard to the questions concerning compensability and the admission of Dr. White's report dated January 12, 1983, we affirm those portions of the Referee's order relevant to these issues.

With regard to the question of the penalty assessed by the Referee for unreasonable denial, we reverse.

Claimant's March 9, 1979 injury claim was originally closed by Determination Order of September 11, 1980. Claimant was awarded temporary total disability benefits from July 23, 1979 through January 13, 1980 and 10% (32°) unscheduled permanent partial disability for injury to the low back. Claimant returned to work and nothing further from a medical standpoint was heard from claimant for over two years.

On December 10, 1982 SAIF received a copy of a myelogram report from Salem Hospital dated November 16, 1982. The report stated that claimant was suffering from a huge recurrent herniated disc at L4-5. Nothing was said concerning any possible relation of the herniated disc to claimant's previous industrial injury.

SAIF asked its neurological consultant, Dr. Brown, for an opinion on the issue of compensability. Although Dr. Brown's December 28, 1982 report, as noted by the Referee, was in large part a discussion of why the claim should never have been ordered accepted in the first instance, Dr. Brown did state that, as there was no medical evidence relating claimant's currently herniated disc to the earlier injury, the claim should be denied.

On January 5, 1983 SAIF denied that claimant had suffered a compensable aggravation of his prior industrial injury.

The only information that SAIF had in its possession at the time of its denial was the November 16, 1982 myelogram report and Dr. Brown's report of December 28, 1982. Neither report even remotely indicated that the claim was or might be compensable. Since the then available information failed to indicate that the claim was compensable, SAIF's subsequent denial, although wrong, could not be said to be unreasonable. Ginter v. Woodburn United Methodist Church, 62 Or App 118 (1983); Mayes v. Boise Cascade Corp., 46 Or App 333 (1980). Even though Dr. White's subsequent report did state that the claim was compensable, the two year lapse of medical treatment and Dr. Brown's report were still sufficient to raise a reasonable doubt concerning compensability. Norgard v. Rawlinsons, 30 Or App 999 (1977). The Referee's assessment of a penalty against SAIF for unreasonable denial is, therefore, reversed.

ORDER

The Referee's order dated December 19, 1980 is affirmed in part and reversed in part. Those portions of the Referee's order which assessed a penalty against SAIF in the amount of 25% of the temporary total disabilty due claimant from claimant's "first day of compensable time loss in the fall of 1982 to and including May 26, 1983," are reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $50 for services on Board review, to be paid by the SAIF Corporation.

FREDERICK G. WEST, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01504
July 16, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Nichols' order which held that: (1) although claimant proved that his chiropractic treatments are related to his compensable low back injury, he had not proved that he was entitled to more than four chiropractic treatments per month; (2) claimant must pay for Dr. Edward Moore's examination because it was conducted for the purpose of litigation preparation; and (3) the insurer was not required to issue a formal denial for the medical services over and above four chiropractic treatments per month.

We affirm the Referee's order with the exception of the Referee's third holding. We have held that, in cases such as this where the insurer denies payment for what it considers to be excessive medical treatment, the insurer has the duty to issue a proper denial with notice of hearing rights in connection with that portion of medical care which is being denied. Billy J. Eubanks, 35 Van Natta 131 (1983).

The events in this case, however, occurred prior to our order in Billy J. Eubanks, supra. The insurer sent a letter to the treating chiropractor and claimant stating that treatment beyond four per month would not be paid, but the letter did not contain the notice of hearing rights. Nevertheless, claimant discovered that he was entitled to a hearing on the medical treatment issue, he requested a hearing and the above hearing was held. Even if we were to determine that a penalty should be assessed for the insurer's failure to issue a formal denial, we would be unable to do so because, since we have determined that the insurer was not obligated to pay for chiropractic treatments in excess of four per month, there are no outstanding amounts due upon which to assess a penalty.

ORDER

The Referee's order dated November 9, 1983 is affirmed.

DEWEY R. BEGLEY, Claimant
Evohl Malagon, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 83-00588
July 18, 1984
Order on Reconsideration

Claimant requests reconsideration of the Board's Order on Review dated June 21, 1984.

The substantive issue that we resolved adversely to claimant's position involves a January 1983 partial denial of continuing psychiatric treatment in connection with claimant's January 1981 compensable back injury. Claimant argues on reconsideration: "The fact that this [psychiatric] condition can be expected to resolve is not the same as proving that it did resolve [by January 1983]." This argument, in our opinion, confuses where the burden of proof lies. Claimant, of course, has the burden of proof. We concluded that claimant did not sustain that burden because we found no evidence that claimant's need for

psychiatric treatment beyond January 1983 was causally related in a material sense to his January 1981 industrial back injury. On reconsideration, we adhere to that conclusion.

Claimant also raises the procedural issue of entitlement to an insurer-paid attorney fee for services rendered on Board review. Claimant cross-requested review on two issues, did not prevail on either, and so is not entitled to a fee in that regard. The insurer requested review on three issues: (1) its partial denial of psychiatric treatment, mentioned above; (2) the extent of claimant's unscheduled back disability; and (3) a penalty issue. Claimant did not prevail on the partial denial issue, and so is not entitled to an attorney fee in that regard. Claimant did prevail on the penalty issue but, because there was otherwise a reduction in compensation, is not entitled to a fee in that regard. See Van DerZanden v. SAIF, 60 Or App 316, 3212 (1982); Korter v. EBI Companies, Inc., 46 Or App 43, 54 (1980). Claimant did prevail on the extent-of-disability issue raised by the insurer on review and, as we understand current case law, is thus entitled to an insurer-paid fee in that regard. See Kociemba v. SAIF, 63 Or App 557 (1983).

ORDER

On reconsideration, the Board's Order on Review dated June 21, 1984 is readopted and republished effective this date with the following addition: Claimant's attorney is awarded $300 for services rendered on Board review in connection with the extent-of-disability issue, to be paid by the insurer.

EMMA J. BOUTWELL, Claimant
Becker, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 83-09330 & 83-09292
July 18, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Farmers Insurance Company, the insurer for the employer, Cabana Coach Company, requests review of Referee Fink's order which set aside its denial and remanded claimant's medical services claim for acceptance and payment of benefits in connection with her 1972 industrial injury. This insurer contends: (1) claimant failed to establish good cause for her failure to request a hearing within 60 days of its denial; and (2) the evidence preponderates in favor of finding that claimant's recent work activity for Intel Corporation independently contributed to her disabling condition, thereby relieving Farmers Insurance Company of further responsibility for claimant's condition.

Claimant's aggravation rights have expired; therefore, the only issue before the Referee pursuant to claimant's hearing request with respect to the 1972 claim, as correctly noted by the Referee, was claimant's entitlement to medical services under the provisions of ORS 656.245, including surgery. Claimant requested that the Board exercise its own motion authority and reopen her 1972 claim. By order dated November 4, 1983, the Board referred claimant's request for own motion relief to the Referee for consolidation with claimant's pending hearing requests and instructed that the Referee make a recommendation with regard to claimant's request for relief pursuant to ORS 656.278. We have

this day entered a separate order in Own Motion No. 83-0318M addressing claimant's request for own motion relief.

On our review of the record, we agree with the Referee's conclusions regarding good cause and employer/insurer responsibility for claimant's current condition. Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated December 9, 1983 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by Farmers Insurance Company.

EVERETT W. JENKINS, Claimant
David Force, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-11565
July 18, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Foster's order which affirmed that portion of the June 30, 1983 Determination Order awarding him 20% (30°) scheduled permanent partial disability for loss of use of his left leg (knee). The SAIF Corporation cross-requests review of that portion of the Referee's order which found claimant was not medically stationary until January 4, 1983, rather than the Determination Order's finding of February 4, 1982.

The Board affirms the order of the Referee with the following comment concerning the issue of extent of permanent scheduled disability.

In rating claimant's permanent disability, the Referee considered claimant's failure to cooperate in his physical therapy program. Claimant contends that under ORS 656.325(4), when confronted with a failure to participate in a physical or vocational rehabilitation program, an employer or insurer may petition the Director for reduction of any benefits awarded to the worker. Here, the Director was not petitioned. Therefore, claimant argues that the Referee should not have considered claimant's failure to cooperate in his physical therapy program when rating his scheduled disability.

A recent Supreme Court decision appears to agree with the Referee's reasoning. See Nelson v. EBI Companies, 296 Or 246 (1984). In Nelson, the court stated that, although ORS 656.325 does not directly apply in rating the extent of permanent disability, the statute indicates a claimant who has suffered injury has a duty to minimize his or her damages. The Nelson court reasoned that an unreasonable failure to follow medical advice was a form of lack of minimization. The burden of proving that the worker unreasonably failed to follow needed medical advice or otherwise failed to mitigate damages rests upon the employer. Nelson, supra, 296 Or at 252. In Nelson, the court concluded that the Court of Appeals had apparently been persuaded by a preponderance of the evidence that the claimant's failure to follow a prescribed weight loss regimen constituted an unreasonable failure to follow needed medical advice.

In the present case, we agree with the Referee's finding that claimant failed to cooperate in his physical therapy program. Further, we are persuaded that SAIF met its burden of proving that claimant's failure to cooperate was unreasonable. Therefore, under Nelson, it is appropriate to consider claimant's failure to cooperate in rating his permanent disability.

Even though claimant's failure to cooperate was not considered, we agree with the Referee that claimant's testimony would not warrant an increased award.

ORDER

The Referee's order dated December 15, 1983 is affirmed. Claimant's attorney is awarded $300 for services on Board review, to be paid by the SAIF Corporation.

RONALD E. JOHNSON, Claimant
Doblie, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-09755
July 18, 1984
Order Allowing Offset and of Dismissal

Claimant has requested review of Referee Danner's order dated January 5, 1984. The self-insured employer has cross-requested review. The parties have now withdrawn their respective requests for review. The employer also seeks Board authorization to deduct a $232.56 overpayment from future compensation. Claimant's attorney does not object to authorizing deduction of the overpayment.

ORDER

The request for review and cross request for review are dismissed. The employer is authorized to deduct $232.56 from future compensation, in accordance with the administrative rules.

DANIEL J. LEATON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-04006
July 18, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Thye's order which refused to award penalties and attorney fees for the SAIF Corporation's late denial of his aggravation claim and which ordered temporary total disability to begin December 6, 1982. Claimant contends that he is entitled to penalties and attorney fees and that he is entitled to temporary disability beginning in October 1982.

The Board affirms the Referee's refusal to award penalties and attorney fees but modifies the Referee's temporary total disability award.

Claimant suffered a compensable low back injury in February 1980, for which he received 10% permanent disability after a

want surgery and returned to work.

In December 1982 claimant returned to Dr. Cummings with complaints of increased pain. Dr. Cummings authorized time loss benefits beginning December 6, 1982 and referred claimant to Dr. Tsai. Claimant gave Dr. Tsai a history of having worked until October 1982 when his back pain forced him to quit work and seek further medical treatment. In January 1983 Dr. Tsai performed a myelogram which showed a herniated disc at L4-5 and surgery was performed.

In March 1983 Dr. Tsai stated that he had reviewed claimant's medical records, which showed claimant had been suffering from an intermittent disc herniation, and stated that claimant had not been able to return to his regular work since October 1982. SAIF agreed to reopen the claim and to begin payment of time loss benefits as of the date of the myelogram. The parties stipulated, however, that the issue of whether claimant was entitled to time loss prior to that date would remain an open issue to be determined by a Referee.

The Referee awarded time loss benefits to begin December 6, 1982 based on Dr. Cummings' authorization. The Referee refused to award time loss back to October 1982, as Dr. Tsai authorized, because that authorization was based solely on claimant's statement that he quit work in October 1982 due to pain and was not based on a medical examination at that time.

First, we do not agree that Dr. Tsai's authorization was based solely on claimant's statement inasmuch as Dr. Tsai stated he reviewed claimant's medical records, which showed that claimant had a herniated disc at least as early as February 1982. Second, even if the authorization was based solely on claimant's statement, it would still qualify as "medically verified inability to work." ORS 656.273(6); see Silsby v. SAIF, 39 Or App 555 (1979). Therefore, we find that claimant is entitled to time loss benefits from October 11, 1982, based on claimant's testimony that he worked for eleven weeks starting July 25, 1982.

ORDER

The Referee's order dated December 23, 1983 is affirmed in part and modified in part. Claimant is awarded additional temporary total disability from October 11, 1982 to the date that the SAIF Corporation agreed to begin payment of those benefits. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25% of the additional temporary total disability ordered herein, to be paid out of claimant's award.

H.D. LORD, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-00209
July 18, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Gemmell's order which granted claimant 112° for 35% unscheduled disability in addition to the 48° for 15% unscheduled [illegible]

Claimant is a 24 year old millwright mechanic who compensably injured his low back on February 12, 1981. Claimant has a lumbosacral strain which limits him to light work. He has above average intelligence and has been trained in electronics work as well as in his former field. Considering the guidelines contained in OAR 436-65-600 et seq. and comparing this case with other similar cases, we conclude that claimant would be adequately compensated by the 48° for 15% unscheduled disability previously awarded by Determination Order.

ORDER

The Referee's order dated November 22, 1983 is reversed. Claimant is granted no award in addition to the 48° for 15% unscheduled disability previously awarded.

WAYNE A. VOLK, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04354
July 18, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Foster's order which found claimant's claim was prematurely closed and which awarded a penalty and attorney's fee for unilateral termination of temporary total disability benefits. Claimant seeks additional penalties. SAIF also contends that the Referee erred in considering certain medical reports. Because the record was left open for depositions concerning the issue of premature closure and because the disputed reports also concerned that issue, we conclude that the Referee did not err in considering those reports.

The Board affirms and adopts the Referee's order on all issues except the issue of penalties and attorney's fees for unilateral termination of temporary disability benefits. On March 7, 1983 Dr. Michael Murphy wrote a report in which he stated:

> "[Claimant] has improved since his last evaluation. He has improved to the point where he can return to his construction work. I believe that 4 to 6 weeks after he returns to his job, he may be declared medically stationary."

On April 11, 1983 Dr. Buza wrote:

> "I am in receipt of Dr. Michael Murphy's report dated March 7, 1983, and I do concur with his note that the patient can return to regular work, that is, within 4-6 weeks after Dr. Murphy has seen the patient which is about the 7th of April, and at the time of this letter, I believe that he is medically stationary if there has not been any interim changes since he was last seen at this office."

SAIF apparently terminated time loss as of the date of Dr. Buza's letter. We interpret the releases of both Dr. Murphy and Dr. Buza as trial releases which do not terminate the duty to pay time loss. Accordingly, SAIF had a duty to continue paying time loss until a Determination Order issued, until claimant actually returned to full time regular work or until he obtained a full release. However, in view of the ambiguous language in the reports, we find that SAIF did not act unreasonably in construing these reports as full releases. Accordingly, we find that SAIF is not liable for penalties or attorney's fees in connection with SAIF's termination of time loss benefits.

ORDER

The Referee's orders dated November 2, 1983 and December 27, 1983 are affirmed in part and reversed in part. Those portions of the Referee's orders assessing a penalty and associated attorney's fee against the SAIF Corporation for unilateral termination are reversed. The balance of the Referee's orders are affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the SAIF Corporation.

DONALD R. CLARK (Deceased), The estate of
Steven Hutchison, Attorney
SAIF Corp Legal, Defense Attorney

WCB TP-84007
July 20, 1984
Third Party Order

This case arises under ORS 656.593, OAR 438-47-010(2) and OAR 438-47-095. The issue is the amount of an attorney's fee which claimant's attorney is entitled to retain from the proceeds of a recovery from a third party civil action. Specifically, the attorney for the beneficiaries of the deceased seeks Board approval for a fee equal to 40% of the recovery obtained on behalf of the beneficiaries.

ORS 656.593(1)(a) provides: "Costs and attorney fees incurred shall be paid, such attorney fee in no event to exceed the advisory schedule of fees established by the Board for such action." OAR 438-47-095 is the Board's administrative rule governing recovery of an attorney's fee out of the proceeds of a third party recovery: "In third party claims, as outlined in ORS 656.593, the attorney's fee shall in no event exceed 33-1/3 per cent of the gross recovery obtained by the claimant." OAR 438-47-010(2) provides in part: "A Referee, the Board or a court may allow a fee in excess of the maximum amount fixed by 47-000 to 47-095 for extraordinary services on a showing by claimant's attorney in a sworn statement the services performed by the attorney."

We have construed these rules to allow the Board to authorize payment of a fee in excess of 33-1/3% where the claimant's attorney makes a satisfactory showing that such an extraordinary fee is warranted and that it is consistent with the retainer agreement entered into between the attorney and the client. Leonard F. Kisor, 35 Van Natta 282, 285 (1983).

Claimant's attorney has failed to provide us with the retainer agreement, and that omission alone prevents us from allowing an extraordinary attorney fee. However, even if the retainer agreement was provided and it did, in fact, indicate that

counsel and his client agreed to an attorney fee equal to 40% of the gross recovery of the third party action, counsel has not provided us with sufficient facts to justify the extraordinary fee.

We have granted extraordinary fees only in those case where the attorney has submitted an affidavit stating specifically the type and extent of extraordinary services anticipated or actually performed. In this case, counsel has given no specific facts as to the work required to obtain the substantial recovery in the third party action but rather bases his request on the statement that: "A 40 per cent of the recovery attorney fee is now a common fee charged against a recovery secured by verdict after trial. Such a fee is reasonable and equitable because it reflects the economic conditions and costs presently existing, and the increased level of work and risk involved in going to trial." Counsel suggests that we should update and revise the advisory schedule of fees to allow a 40% recovery attorney fee when the recovery is based on a verdict after trial. Counsel further suggests that: "The advisory schedule of fees should reflect economic reality and the market place and the actual reasonable and equitable amount that will encourage contingency work by private attorneys. The benefits to the Workers' Compensation System are tremendous. Private lawyers handling third-party claims on a contingency basis provide a body of risk-taking entrepeneurs putting their time and staff time into cases where there may be substantial risk of loss."

While counsel's general statements above are certainly factors to be considered upon a future review of the advisory schedule of attorney fees, it is not sufficient to justify an allowance of an extraordinary fee in this case. See, for example, the factors set out in Leonard F. Kisor, 35 Van Natta 282 (1983); John Galanopoulos, 34 Van Natta 615 (1982), 35 Van Natta 558 (1983); and John C. Hale, 36 Van Natta 585, 36 Van Natta 701 (1984).

Should counsel wish to submit the retainer agreement and an affidavit setting out specifically the basis for his request for an extraordinary attorney fee, we will reconsider this decision.

IT IS SO ORDERED.

MARILYN J. CLEMONS, Claimant
Bischoff & Strooband, Claimant's Attorneys
Gilah Tenenbaum, Defense Attorney
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11229, 82-11493 & 83-08716
July 20, 1984
Order Denying Motion to Strike

Claimant moves to strike the SAIF Corporation's reply brief on the ground that it was untimely filed.

Although claimant is correct that SAIF's reply brief was not timely filed, it is not so late as to delay review. Considering the importance of briefs to our review, claimant's motion to strike is denied.

IT IS SO ORDERED

ROBERT L. MARVIN, Claimant
Van Vactor, et al., Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 81-06759
July 20, 1984
Order on Remand

On review of the Board's order dated April 19, 1983, the Court of Appeals reversed the Board's order and remanded the case to the Board with instructions to grant claimant an award for permanent total disability.

Now, therefore, claimant is granted an award for permanent total disability. Claimant's attorney is allowed an award of 25% of the increased compensation, not to exceed $1,000, for services before the Board; in addition claimant's attorney is allowed an award of 25% of the increased compensation, not to exceed $2,600, for services before the Court of Appeals.

IT IS SO ORDERED.

ROBERT W. STEDMAN, Claimant
Black, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 81-01763
July 20, 1984
Order on Remand

On review of the Board's order dated May 6, 1983, the Court of Appeals reversed the Board's order.

The Board's order dated May 6, 1983 is, therefore, vacated. This claim is remanded to the self-insured employer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED

MERVYN A. TOYNTON (Deceased), The estate of
Barton & Armbruster, Attorneys
Frank A. Moscato, Attorney

WCB TP-84008
July 20, 1984
Third Party Order

This case arises under ORS 656.593, OAR 438-47-010(2) and OAR 438-47-095. The issue is the amount of an attorney's fee which claimant's attorney is entitled to retain from the proceeds of an anticipated recovery from a third party civil action. Specifically, the attorney for claimant's estate seeks Board approval for a fee schedule equal to 33-1/3% to 50% of the anticipated recovery obtained on behalf of claimant's estate.

ORS 656.593(1)(a) provides: "Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the Board for such action." OAR 438-47-095 is the Board's administrative rule governing recovery of an attorney's fee out of the proceeds of a third party recovery: "In third party claims, as outlined in ORS 656.593, the attorney's fees shall in no event exceed 33-1/3 per cent of the gross recovery obtained by the claimant." OAR 438-47-010(2) provides in part: "A Referee, the Board or a court may allow a fee in excess of the maximum amount fixed by 47-000 to 47-095 for extraordinary services on a showing by claimant's attorney in a sworn statement the services performed by the attorney."

We have construed these rules to allow the Board to authorize payment of a fee in excess of 33-1/3% where the claimant's

attorney makes a satisfactory showing that such an extraordinary fee is warranted and that it is consistent with the retainer agreement entered into between the attorney and the client. Leonard F. Kisor, 35 Van Natta 282, 285 (1983).

A copy of the retainer agreement entered into between the personal representative for claimant's estate and the attorney indicates that the attorney would be entitled to a contingent fee of 33-1/3% of the gross recovery if the case is settled without the trial beginning, 40% should the trial begin and 50% if appellate proceedings are initiated or if a second trial is commenced.

The remaining question is, then, whether counsel's anticipated services are extraordinary within the meaning of OAR 438-47-010(2).

Leonard F. Kisor, supra, was a case in which we approved a fee over and above the 33-1/3% of the gross recovery for anticipated extraordinary services. That case involved Federal District Court litigation in the state of Washington, initiated by the deceased worker's widow, against various asbestos manufacturers whose products allegedly caused the worker's death as a consequence of mesothelioma. Portland counsel necessarily associated local counsel in Seattle, Washington. The third party action named approximately 30 defendants and involved complex issues of proximate causation. Similar cases of this nature were cited by claimant's attorney in support of their claim for an extraordinary fee. It was indicated that those cases had involved approximately 78,000 pages of documentary materials. Based upon those facts and circumstances, we found it appropriate to approve an attorney fee in the amount of 40% of the total recovery of the third party action.

In John Galanopoulos, 34 Van Natta 615 (1982), 35 Van Natta 558 (1983), we approved a 40% extraordinary attorney fee for services already rendered. That case involved a malpractice action against a podiatrist. Counsel's affidavit stated that for three months prior to trial, his representation of claimant required the vast majority of all of his working time. He was required to extensively interview claimant, members of his family and friends. He was required to engage in fairly extensive medical research, and he interviewed several local podiatrists regarding the standards of care for a podiatrist treating this type of injury. The results obtained, $139,000, were substantially above what a former attorney had recommended as a reasonable settlement ($10,000). The trial itself lasted five days.

In John C. Hale, 36 Van Natta 585, 36 Van Natta 701 (1984), we denied an extraordinary fee in excess of 33-1/3%. In that case claimant's counsel stated that he expended over 200 hours in representing claimant, which included two or three trips to California for purposes of investigation and deposition. The third party had contended that claimant was solely liable for the accident which resulted in claimant's injury. There were protracted discovery proceedings characteristic of federal court litigation. Counsel had expertise in federal court tort litigation. It was necessary to advance substantial out-of-pocket costs to claimant, and the trial required three days.

In the case before us, counsel for claimant's estate states that this action will involve a third party products liability and negligence action against General Electric. There will likely be cross-claims and allegations of comparative fault. Counsel has expertise in trying products liability cases, an area of law which is complex and in a state of flux. Counsel states he is an experienced trial attorney, currently president of the Oregon Trial Lawyers Association and serves on the Board of Governors of Western Trial Lawyers. He believes that the fee agreement is fair, given the state of Oregon law, the considerable resources of General Electric, probability of cross-claims and allegations of comparative fault. Further, he anticipates there will be extensive preparation and a large number of expert witnesses.

We do not find, on the information presently before us, that counsel has shown that the anticipated efforts which he must expend are comparable to that shown in cases where we allowed an extraordinary attorney fee. Should the facts and circumstances change, however, counsel may submit a further affidavit to us and ask that we reconsider our decision.

IT IS SO ORDERED.

SHARON J. ANDERS, Claimant
Myrick, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 82-10877
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Brown's order which affirmed the insurer's October 21, 1982 denial of aggravation for claimant's cervical injury. Claimant contends that the preponderance of the medical evidence shows that claimant's present cervical condition, diagnosed as traumatic aggravation of preexisting spondylosis with chronic cervical strain, is related to her August 7, 1978 cervical injury and has worsened since the last arrangement of compensation, September 9, 1981.

We agree with claimant and reverse the Referee's order.

On August 7, 1978, while employed as a plywood mill worker, claimant developed neck and accompanying arm pain. She was referred to Dr. Mario Campagna, neurologist, who diagnosed nerve root irritation at C6, bilaterally, secondary to cervical spondylosis at C5-6 which was aggravated by her employment. X-rays of her neck taken at Southern Oregon Hospital showed minimal disc space narrowing at the C5-6 interspace.

Claimant had been asymptomatic prior to the work injury, but afterwards her neck and bilateral arm pain continued with weakness in both arms. Her first Determination Order, dated February 25, 1980, awarded time loss benefits and 5% unscheduled permanent partial disability. Thereafter, claimant's condition worsened, and a second Determination Order dated June 13, 1980 awarded time loss benefits and an additional 5% unscheduled permanent partial disability. Claimant entered into a vocational rehabilitation training program to learn secretarial skills and that program was closed with a Determination Order dated September 9, 1981. No additional permanent disability benefits were awarded at that time.

The next month claimant moved to Oklahoma where she found a job as a clerk. In February 1982 claimant was examined by Dr. Richard Dotter, an Oklahoma City neurologist, on referral by Dr. Ethel Walker. He felt claimant's neck and headache complaints were primarily muscular. Dr. Walker restricted claimant from work February 16, 1982 to March 11, 1982. Beginning March 11, 1982, it was Dr. Dotter who authorized time loss. Claimant's muscle stiffness and pain in her neck and headache were gone, but she still had an aching in her arms. Dr. Walker released claimant to return to work April 1, 1982, at which time she began working at a deli, serving food and washing pots.

Dr. Dotter's closing report of October 9, 1982 stated:

> "It is my opinion that there is no evidence that her condition has significantly worsened since that report by Dr. Campagna [dated April 30, 1981]. Her present medical complaints are precisely those as outlined in his summary letter, and as such represent a continuation of her complaints from August of 1978."

Dr. Campagna's report of April 30, 1981 had noted:

> "She states she still is having muscle spasms in her neck that radiate into her shoulder blades and into her upper back. She states she is also getting headaches from the spasms and the right side of her neck is sore all the time. She states that her arms ache to her elbows."

Thereafter, on October 21, 1982, the insurer denied claimant's aggravation claim on the ground that there was no worsening.

On November 1, 1982 Dr. John Hughes, orthopedic surgeon at Oklahoma City, x-rayed claimant's cervical spine and diagnosed degenerative disc disease between C5 and C6 with anterior osteophyte formation. It was his opinion that the degenerative process was the end result of her injury situation. Due to a negative EMG test, he did not think surgery was warranted, but felt that in the future claimant may well require an anterior interbody cervical fusion.

Shortly after this, claimant returned to Oregon to her original treating physician, Dr. Robert Strukel. Dr. Strukel referred claimant to Dr. Ruben Saez, neurosurgeon. Dr. Saez examined claimant on December 8, 1982 and noted her complaints of neck pain and stiffness with headaches, bilateral arm pain, worse in the left than right, and occasional numbness of the left hand. Claimant's neck motion was between 50% and 75% of normal. There was hypesthesia of the second and fifth fingers of the left hand. Dr. Saez diagnosed cervical disc disease at C5-6 that was aggravated by the 1978 injury. Dr. Saez also noted that claimant was diagnosed as suffering from tension in 1979 and that such impressions still appeared applicable. Dr. Saez recommended that conservative management of her condition be continued unless significant neurologic impingement was found to exist in the

cervical spine. He admitted claimant to the hospital for evaluation and a January 17, 1983 myelogram revealed a posterior osteophytic ridge at C5-6 indenting the dural sac at that level with mild obliteration of the nerve root sleeves bilaterally.

In a report dated January 19, 1983, Dr. J. W. Gilsdorf took a history of claimant's continuing cervical disability since 1978 with limited ability to work since that time. Dr. Gilsdorf noted that claimant's condition had intermittently responded to traction and rest:

> "Through the years, she has noted a [sic] specific positions and activities that will always precipitate discomfort. She cannot tolerate sustained reaching or looking overhead because of the production of headaches and aching into her left upper extremity. She cannot tolerate holding her grandchildren on her left arm as this involves tilting her head to the left lateral position with slight rotation, and she promptly then experiences posterior cervical pain, aching into the left upper extremity, and a sense of numbness usually involving the index finger and ring finger.
>
> "She is also aware that any activities to and fro or repetitive turning of the neck produces posterior cervical discomfort, headaches, and thereafter increasing pain in her left upper extremity. Riding in a car or driving produce increased symptoms.
>
> "Recumbency and marked restrictions of activities, avoiding these aggravating positions and motions will result in good relief of discomfort. If she conscientiously avoids these aggravating positions, activities can remain relatively comfortable for even sustained periods of time, but at times there has occurred episodes of recurrent posterior cervical pain and aching when she could not recognize any period of aggravating activity or positioning."

The doctor's diagnosis was that of cervical spondylosis at C5-6 with intermittent radiculopathy. The doctor found that her description of aggravating conditions and postures was "certainly consistent with her degree and area of spondylosis." He felt that conservative treatment could continue to be carried out if claimant could be able to live with her current level of problems and limit her physical capacities. However, he recommended, based on her long history and her x-ray findings, that if claimant felt she could not continue to tolerate her current level of restriction and discomfort, then anterior cervical discectomy and interbody fusion at C5-6 was indicated.

Dr. Saez concurred with Dr. Gilsdorf's opinion that claimant should attempt to accept her present symptoms, but stated that, if

she remained significantly symptomatic, claimant would be advised to undergo a decompression and fusion at C5-6.

Claimant was released from the hospital January 20, 1983 and returned to see Dr. Saez a month later. Upon her return, she reported continuing neck pain with cervical movement, intermittent headaches accompanying that pain, and pain and stiffness radiating out into the left shoulder with aching of the upper arms bilaterally. Claimant reported that even ordinary house activities were enough to trigger the recurrent symptoms every day. Cervical range of motion was 75% of normal. At that time Dr. Saez recommended that the cervical discectomy and fusion be performed as there appeared to be "no reasonable alternative to manage her continuing symptoms with any expectation of success."

On April 19, 1983 Dr. Saez reported that it was his medical opinion that claimant had preexisting cervical spondylosis of a mild degree which was asymptomatic before her neck was worsened by the injury of 1978. Since that time claimant's work efforts had been unsuccessful due to a gradual worsening of her symptoms. Also a recent cervical myelogram indicated that the defect at C5-6 was more prominent than it had been on previous studies. Dr. Saez's opinion was that claimant's 1978 injury was the major cause of worsening of the patient's previously asymptomatic condition, and that since that time naturally progressive changes in the cervical spine were also secondarily contributory to the patient's condition as it presently existed.

The insurer then referred claimant to Dr. Luce, a neurosurgical consultant, who had examined claimant previously as a member of the Southern Oregon Medical Consultants' panel in 1980. Besides examining claimant, Dr. Luce also had access to the previous medical records. Dr. Luce made the following comparisons between claimant's past and present condition:

> "The neck stiffness is nearly always present and it is frequently followed by the headaches as described above. Her left arm aches more constantly at the present time, particularly in the elbow area. She emphatically states that there is never any elbow discomfort without having antecedent neck pain and discomfort. Her position of comfort is lying flat with a pillow and she states that her positions of discomfort are trying to sit for any length of time or driving a car for any distance, because of the necessity for turning her head from side to side."

Dr. Luce noted a change in claimant's cervical spine at C5-6. When comparing past and recent myelograms it was suggested that claimant now had a very prominent spur and perhaps some added disc material or, in the alternative, a free fragment which had some calcium deposit in that area. It was Dr. Luce's opinion that there had been a progression of symptoms compatible with the injury and the anatomical alterations which had followed it. Dr. Luce had the opinion that the surgery recommended by Dr. Saez and Dr. Gilsdorf was necessary for the reasons of the underlying post-traumatic changes, and not necessarily because of the natural

progression of some nontraumatic disease, i.e., cervical spondylosis. Dr. Luce felt claimant would be a good surgical candidate as she was a woman who wants to work, but had been too uncomfortable to carry out work activities.

At hearing, the insurer introduced the testimony of Dr. Eugene Tennyson, Jr., neurosurgeon, who had reviewed the medical reports and x-rays, but did not examine claimant. It was Dr. Tennyson's opinion that claimant's present condition reflected only the natural progression of the underlying condition of cervical spondylosis. Dr. Tennyson had the opinion that claimant's findings of cervical spondylosis were about average for someone of her age. He also felt that, if claimant's August 1978 injury had an effect upon claimant's spondylosis, it should have shown up in the first myelogram which he interpreted as being normal.

The record shows, however, that the first myelogram, performed by Dr. Campagna, was not normal. It revealed a small to moderate size anterior extradural defect at C5-6, associated with a posteriorly projecting osteophytic spur at C5. A smaller defect was present at C6-7.

Dr. Tennyson further stated that there was no change in claimant's neurological findings between 1979 and 1983, except for an improvement in her cervical range of motion. However, Dr. Luce's April 22, 1983 report revealed that, upon neurological sensory examination, there was slight hypesthesia over the left ring and index fingers. On palpation, Dr. Luce found:

> "The suboccipital areas are tender, bilaterally, more on the left side than the right. The paravertebral musculature is quite tight on the right side, and it is tender throughout the cervical area. The trapezius on the left is very tender over the superior portion of that muscle. The rhomboids are normal bilaterally. The spinous processes are normal except for tenderness over C-1 and C-5 in the midline."

One of Dr. Luce's diagnoses was "recurrent nerve root irritation, C-6 left."

The Referee accepted Dr. Tennyson's opinion over that of Dr. Saez and Dr. Gilsdorf because he felt the latter two doctors' opinions did not state convincingly that the worsening was a result of the compensable injury. The Referee determined that Dr. Luce's opinion should be given less weight than Dr. Tennyson's because, even though Dr. Luce may be in a better position to determine whether claimant's condition had worsened based on his ability to make a comparative exam, he did not have an advantage in discussing etiology of claimant's present condition.

Our de novo examination of the doctors' opinions leads us to a different conclusion. We find that greater weight should be given to the opinions of the treating neurosurgeon, Dr. Saez, and his consultant, Dr. Gilsdorf, who actually examined claimant. We also find that considerable weight should be afforded Dr. Luce's opinion because he actually examined claimant and had the advantage of comparing claimant's present condition to her

condition three years earlier.

Dr. Tennyson had neither the advantage of examining claimant nor of viewing her condition over a period of time. Although his conclusions are possible, we find them less persuasive than the other available medical opinion. For the above reasons, we reverse the Referee's order and find that claimant has proved by a preponderance of the evidence that her cervical condition, which now requires surgery in the opinion of her treating doctors, is related to her 1978 compensable neck injury.

ORDER

The Referee's order dated August 5, 1983 is reversed. Claimant's aggravation claim is remanded to the insurer for processing and payment of benefits. Claimant's attorney is awarded $600 for services on Board review and $1,000 for services at hearing, to be paid by the insurer.

ANITA A. BADE, Claimant
Glenn Ramirez, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-10966
July 23, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Brown's order which upheld the insurer's denial of medical treatment. The issue is claimant's entitlement to medical services pursuant to ORS 656.245.

The insurer contends that the Referee erred, albeit harmlessly, in assigning it, rather than claimant, the burden of proof in this case. In addition, the insurer has raised a preliminary issue by way of a "Motion to Strike" portions of claimant's brief. The insurer contends that claimant raises a new issue (in the nature of a collateral estoppel argument) on review.

The insurer's motion is denied. We do not consider claimant's estoppel argument to be a "new issue" which claimant has waived by her failure to raise it at hearing. Rather, claimant is advancing another legal theory in support of the only issue in this case: Her entitlement to medical services pursuant to ORS 656.245. There is sufficient evidence in the record to decide the merits of claimant's estoppel argument. See also Anderson v. West Union Village Square, 44 Or App 685, 688 (1980); Neely v. SAIF, 43 Or App 319, 323 (1979). We do not believe the insurer is prejudiced by the fact that claimant argues this estoppel theory for the first time on review, particularly in view of our conclusion that claimant's argument must fail.

Claimant was 58 years of age at the time of hearing. She sustained this industrial injury on February 7, 1976 when a door blew out of her hand and struck her chest. Prior to this accident, claimant had been involved in three motor vehicle accidents, which resulted in cervical, thoracic and low back complaints. The 1976 industrial injury apparently aggravated this entire symptom complex. The 1976 claim was accepted and processed to closure by a Determination Order which awarded 5% unscheduled low back disability.

In early 1978 an issue arose concerning claimant's entitlement to chiropractic treatment. On the basis of recommendations made by a peer review committee and an opinion issued by the Medical Director of the Workers' Compensation Department, the insurer denied payment of further chiropractic treatment "beyond August 23, 1977," by denial letter dated March 13, 1978. In a prior proceeding, WCB Case No. 78-00304, a Referee affirmed the Determination Order award of 5% unscheduled low back disability and set aside the insurer's March 1978 denial, ordering that "after August 23, 1977, the [insurer] provide claimant all injury related benefits due her pursuant to ORS 656.245. . . ."

In February 1979, in response to a letter from claimant's chiropractor, the insurer denied reopening the claim for the asserted reason that claimant's "current condition [was] not a natural worsening or progression of [her] incident of February 4, 1976, but [was] causally related to [her] current employment." Claimant apparently requested a hearing contesting this denial (WCB Case No. 79-01326), and claimant and the insurer entered into a stipulation, which was approved by a Referee in December of 1981, whereby the insurer agreed to pay "all medical claims and expenses submitted to date," and an insurer-paid attorney's fee.

In August 1982 claimant's chiropractor requested that the Northwest Pain Center admit claimant for examination and treatment. The Center requested that the insurer authorize treatment. The insurer first had claimant examined by Dr. Lynch, who opined that claimant was experiencing no residual symptoms from her February 1976 industrial injury. After receipt of Dr. Lynch's report, the insurer denied claimant's request for admission to the Northwest Pain Center "and subsequent time loss." The denial letter states:

> "Our review indicates that your present condition and need for ongoing medical care is not causally related to the industrial injury of February 4, 1976. Further, you terminated with our employer on June 2, 1976, and any symptoms that you are now having are more probably related to the repetitive lifting and bagging of groceries since June 2, 1976. We are, therefore, denying [your] request for admittance to the Northwest Pain Center since your present condition did not arise out of and/or in the course of your employment."

Claimant requested a hearing contesting this denial, which gave rise to the present proceeding.

Before the hearing convened in August 1983, the insurer's attorney advised claimant and the Board of its understanding of the issues for hearing:

> "It is employer's position that the denial letter dated November 22, 1982, while specifically responding to a request for admittance to the Northwest Pain Center also denies that claimant's current condition and need for medical care and

> treatment is not causally related to the industrial injury of February 4, 1976. It is employer's position that this denial serves to deny the compensability of the chiropractic treatment being rendered by Dr. Mark D. Heller as set forth in Exhibits 46 and 47."

When the hearing began on August 31, 1983, the stated issues were claimant's entitlement to payment of medical bills for treatment incurred as of the time of hearing, claimant's entitlement to receive "further medical treatment" and whether the insurer's claim processing warranted imposition of penalties and attorney fees. The Referee's order concludes, "the employer's denial for current and future medical treatment arising out of the February 4, 1976 injury is sustained."

First we consider claimant's argument that the insurer is estopped to deny claimant compensation under the provisions of ORS 656.245. It is unclear whether claimant is arguing that the Referee's 1978 order in WCB Case No. 78-00304 or the 1981 stipulated order in WCB Case No. 79-01326 forms the basis of this alleged estoppel. In either event, the result is the same.

The litigation which led to the 1978 Referee's order was concerned with the extent of claimant's permanent disability and claimant's entitlement to additional chiropractic treatment. The treatment issue at that time was not the causal relationship between claimant's 1976 injury and the condition requiring chiropractic treatment; rather, the issue was the reasonableness and necessity of the amount of treatment being rendered. Based upon his conclusion that claimant would require palliative treatment from time to time, the Referee ordered the insurer to pay these benefits pursuant to ORS 656.245. This prior litigation, therefore, could not be determinative of the insurer's obligations and the claimant's rights with respect to chiropractic or medical care in this litigation, where the issue is the causal connection between claimant's original injury and the condition or conditions now requiring treatment. No estoppel arises from the 1978 order.

The insurer's February 1979 denial did raise an issue concerning the causation of the condition requiring chiropractic care at that time, and whether it was related to claimant's 1976 injury. However, the stipulation signed by the parties and approved in December 1981 could not be more clear in defining the parties' rights and obligations. That stipulation states that the insurer "will pay all medical claims and expenses submitted to date." (Emphasis added.) That stipulation did not resolve any issue concerning claimant's possible continuing entitlement to medical services pursuant to ORS 656.245; it merely resolved the dispute between the parties concerning claimant's entitlement to the treatment incurred as of the date of the agreement. Cf. Clinkenbeard v. SAIF, 44 Or App 583 (1980). No estoppel arises from the 1981 stipulation.

On the merits of the issue decided by the Referee -- claimant's entitlement to benefits pursuant to ORS 656.245 -- we agree with the Referee's conclusion that a preponderance of the persuasive evidence fails to establish the requisite causal

relationship between claimant's 1976 industrial injury and the medical condition presently requiring chiropractic care. Similarly, the evidence fails to establish that the proposed admission to the Northwest Pain Center is for treatment of an injury-related condition. The evidence rather clearly establishes that claimant's current medical condition is primarily due to causes other than claimant's industrial injury, including claimant's prior motor vehicle accidents, and her osteoporosis and degenerative spinal changes, neither of which were caused by or are otherwise related to the 1976 injury.

Finally, we agree with the insurer's position that the Referee erred in assigning the burden of proof to it. When an employer/insurer denies the compensability of a claim, the claimant must prove entitlement to compensation by a preponderance of the evidence. Hughes v. Pacific Northwest Bell, 61 Or App 566, 571 (1983); Brewer v. SAIF, 59 Or App 87, 90-91 (1982); Lenox v. SAIF, 54 Or App 551, 553 (1981); Denny v. SAIF, 48 Or App 335, 337 (1980); Fisher v. Consolidated Freightways, Inc., 12 Or App 417 (1973); Robert F. Maxwell, 35 Van Natta 1244, 1247 (1983); Eugene Voris, 35 Van Natta 598 (1983), aff'd without opinion, 66 Or App 972 (1984); Mary E. (Southworth) Osborne, 35 Van Natta 186, 188 (1983), aff'd without opinion, 65 Or App 567 (1983); Eonia Z. Stoa, 34 Van Natta 1206 (1982).

ORDER

The Referee's order dated September 29, 1983 is affirmed.

LORRI K. DAY, Claimant
Doblie, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-07346
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Quillinan's order which: (1) Found claimant's out-of-state medical treatment to be compensable and (2) assessed it a penalty and attorney fees for unreasonable conduct in refusing to authorize the proposed medical treatment.

Claimant compensably injured her low back in June 1981. Dr. Whitney, claimant's treating orthopedist, recommended a laminectomy and diskectomy. The insurer denied responsibility, contending claimant's disc problem was not work-related. This denial was set aside by a Referee's order of July 22, 1982 which was affirmed by the Board. Lorri K. Day, 35 Van Natta 500 (1983).

In June 1982 claimant learned of a new procedure called percutaneous neuclectomy. This treatment consisted of an arthroscopic procedure in which fragmented material was removed mechanically. Claimant contacted Dr. Morris, an orthopedic surgeon in California, concerning the treatment. Dr. Morris is one of the two physicians in the country who presently performs this type of operation.

In late August 1982 claimant discussed Dr. Morris' treatment with Ms. Catherine Henry, the insurer's claim representative. On August 24 Ms. Henry wrote claimant reiterating that the insurer

would not be responsible for expenses and payments generated by claimant's choice of a treating physician outside of Oregon.

Claimant testified that she informed Ms. Henry how to contact Dr. Morris. She did not provide the insurer with any other information concerning the treatment.

Ms. Henry testified that she advised claimant several times that the surgery performed by Dr. Morris was not authorized. Ms. Henry understood that claimant would have Dr. Morris contact the insurer. Ms. Henry was not contacted by Dr. Morris prior to the surgery, nor did Ms. Henry receive any documentation from Dr. Whitney recommending the neuclectomy. Ms. Henry also stated that in a September 21 phone conversation with claimant, they discussed an independent examination to be conducted by any of a number of doctors. Claimant acknowledged that the September 21 conversation took place. However, she testified that no agreement was ever reached nor was she advised of an appointment date for an examination.

By letter dated September 29, the insurer's counsel advised claimant's counsel that claimant's out-of-state treatment was not authorized.

On October 3 claimant was examined by Dr. Morris in California. Dr. Morris advised claimant that the results of the neuclectomy would be compromised if she delayed further.

On October 12 Ms. Henry was contacted by the administrator for a California hospital. The administrator advised Ms. Henry that claimant's operation was scheduled to begin and requested authorization for the surgery. Ms. Henry did not authorize the surgery.

The surgery was performed. Claimant testified that at no time did she understand that the surgery was authorized by the insurer.

Claimant requested a hearing on the insurer's August 23, 1982 and September 29, 1982 refusals to authorize Dr. Morris' treatment. The Referee found that the out-of-state treatment was compensable, set aside the insurer's refusals to authorize Dr. Morris' treatment and assessed a penalty and attorney fees for unreasonable conduct in processing the claim.

We disagree. Therefore, we reverse.

Pursuant to ORS 656.245 a compensably injured worker has an absolute right to choose an attending physician within the State of Oregon. However, ORS 656.245(3) limits a worker's choice of doctors when the worker seeks treatment in another state. See Rivers v. SAIF, 45 Or App 1105, 1108 (1980), which interpreted ORS 656.245(3), entitled subsection (2) at that time. Under ORS 656.245 and Rivers, it would appear that the insurer, within reasonable limits, has an absolute right to refuse a claimant's choice of an out-of-state doctor.

Furthermore, since the Referee's order, the Court of Appeals has issued its opinion in Mogliotti v. Reynolds Metals Company, 67 Or App 142 (1984). In Mogliotti, the court held that if an insurer gives a claimant a reasonable basis to believe the insurer

has approved the claimant's choice of an out-of-state doctor, the claimant need not obtain the insurer's consent to medical services provided by the doctor for conditions resulting from the compensable injury.

The Mogliotti court found that its conclusion was consistent with OAR 436-54-245(5) which states:

> "(5) When the worker chooses an attending physician outside the state of Oregon, the insurer or self-insured employer may object to the worker's choice and select the attending physician. Payment for treatment or services rendered to the worker after the insurer or self-insured employer has objected to the worker's choice of attending physician may be rejected by the insurer or self-insured employer."

The court in Mogliotti found several factors significant in finding that authorization was not required. Although the insurer initially told the claimant that he could not choose his out-of-state doctor, it did not specifically object to the claimant's choice nor in a timely manner select an alternate physician. Also, in the approximately two months time preceding the surgery, the insurer never advised the claimant that the proposed laminectomy by the out-of-state doctor was not authorized. Further, the insurer had paid expenses stemming from the doctor's treatments prior to the claimant's surgery. Finally, when the claimant advised the insurer a few days before the surgery that the operation was scheduled, the insurer responded "Fine, we will open your file." The Mogliotti court concluded that the insurer's actions had given the claimant a reasonable basis to believe the surgery performed by the out-of-state doctor had been approved.

In the present case, the facts do not support such a conclusion. Throughout the approximately two month period leading up to the neuclectomy claimant understood that the surgery was not authorized. In addition, claimant acknowledged that the subject of an alternative examination had been discussed. At no time did the insurer modify its position that the treatment by Dr. Morris was unacceptable. The most that could be interpreted from the insurer's actions was that the insurer offered claimant an opportunity to produce information on the new procedure.

Therefore, we find that the insurer's actions did not give claimant a reasonable basis to believe the surgery was authorized. The treatment administered by Dr. Morris was not compensable.

Since we find that the insurer's de facto denials should not have been set aside, it follows that the insurer's conduct in refusing to authorize the proposed treatment could not have been unreasonable.

ORDER

The Referee's order dated November 9, 1983 is reversed. The insurer's August 23, 1982 and September 29, 1982 de facto denials of authorization of Dr. Morris' treatment are reinstated and affirmed.

JOHN D. FISCHER, Claimant
David Force, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 83-06397 & 83-05117
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Braverman's order which upheld the employer's denial of his stress claim and which declined to award claimant any temporary disability benefits. Compensability of the stress claim and claimant's entitlement to temporary disability benefits are the issues on review.

The Board affirms and adopts those portions of the Referee's order concerning the compensability of claimant's mental stress claim.

On the issue of claimant's entitlement to temporary disability benefits, we reverse the Referee. It is not completely clear whether claimant's mental stress problems are alleged to be related to a compensable injury or are alleged to be an occupational disease caused by stress at work. However, upon a close examination of the record, including the parties' arguments, we conclude that claimant is asserting an occupational disease claim. Claimant's psychologist first took him off work for psychological reasons on March 16, 1983. However, claimant concedes that the employer's first notice that his psychological problems were allegedly caused by his work was on April 20, 1983 when claimant wrote the following note to his employer:

> "I am requesting a temporary layoff with medical benefits. I have been off since March 14, 1983 for mental health reasons without compensation. The problem has been determined to be job related, therefore, I am requesting that the compensation be made retro-active to March 14, 1983 for financial reasons."

Claimant did not actually file an 801 form for his psychological problems until June 13, 1983. The employer issued its denial on June 30, 1983. We conclude that because the employer had notice of a new claim on April 20, 1983, claimant is entitled to interim compensation from April 20, 1983 until the denial. Claimant seeks no penalties or related attorney's fees and none are awarded.

ORDER

The Referee's order dated December 6, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which declined to grant claimant an award for temporary disability is reversed. Claimant is awarded temporary disability benefits from April 20, 1983 until June 30, 1983. The balance of the Referee's order is affirmed. Claimant's attorney is allowed 25% of the increased compensation awarded by this order, not to exceed $3000.

NORMAN L. GARBUTT, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 80-11364
July 23, 1984
Order on Remand

This extent of permanent disability case is before the Board on remand from the Supreme Court, which stated:

> "In reviewing the Board's order in this case, we cannot determine if the Board, as did SAIF, believed medical testimony was statutorily required or simply that the Board was unconvinced by the lay testimony and without medical evidence could not resolve the issue. If based on the latter, the Board's decision is legally correct; if based on the former, the Board should reevaluate its decision in light of all the credible lay and expert or professional medical evidence." Garbutt v. SAIF, 297 Or 148, 152 (1984).

Garbutt held that lay testimony may or may not carry the worker's burden of proving extent of disability, but medical evidence is not statutorily required to establish such disability.

Claimant suffered a compensable right shoulder injury in November 1975. After participating in a vocational program and returning to work, claimant developed problems in his left shoulder. After a hearing in March 1982 claimant was awarded permanent total disability by the Referee's order dated July 21, 1982. On review, the Board reversed the Referee's order and reinstated claimant's prior award of 30% unscheduled permanent disability. Norman L. Garbutt, 35 Van Natta 262 (1983). After the Court of Appeals affirmed without opinion, 65 Or App 568 (1983), the Supreme Court reviewed the case and remanded to the Board as discussed above.

Having further reviewed this case on remand and having no reason to reject the Referee's credibility finding, we accept claimant's and his wife's credible testimony of claimant's physical limitations and disabling pain. Although we still do not believe claimant is permanently and totally disabled, we find that claimant is entitled to a permanent disability award greater than the 30% previously awarded.

In rating claimant's loss of earning capacity resulting from his compensable injury we have evaluated claimant's impairment due to his right and left shoulder injuries in light of the testimony of claimant, his wife and the doctors who have examined him. Also we have considered claimant's age of 55 at the time of hearing, his tenth grade education and other relevant social and vocational factors. ORS 656.214(5). Considering these factors and comparing this case with other similar cases, we find that claimant is entitled to an award of 45% (144°) permanent partial disability, in lieu of the 30% (96°) previously awarded.

ORDER

The Referee's order dated July 21, 1982 is reversed. Claimant is awarded 45% (144°) unscheduled permanent partial disability in lieu of all prior awards. Claimant's attorney's fee shall be adjusted accordingly.

DAVID L. HUNT, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 83-09600
July 23, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of those portions of Referee Brown's order which upheld the insurer's denial of claimant's aggravation claim.

In one portion of his analysis, the Referee cited Oakley v. SAIF, 63 Or App 433 (1983), for the proposition that Dr. Link's October 31, 1983 report was "legally insufficient" to establish an aggravation claim. We note that, since the Referee issued his order, the Supreme Court has criticized Oakley in Garbutt v. SAIF, 297 Or 148 (1984). We nevertheless agree with the Referee's conclusion, not because any particular medical report is "legally insufficient," but because we are not persuaded that claimant has proved a compensable aggravation considering all the evidence.

ORDER

The Referee's order dated December 7, 1983 is affirmed.

HOWARD H. HURST, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01616
July 23, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Williams' order which set aside SAIF's denial of claimant's myocardial infarction claim. The sole issue is compensability.

Claimant is a 52 year old elected union employe who negotiates union contracts and performs other union duties. In 1974, 1977 and 1979 claimant sought medical treatment for chest pain and/or fatigue possibly related to congestive heart failure. On the morning of October 4, 1982, the day before his heart attack, claimant had an intense and heated encounter at a job site. Claimant said that after the morning incident, he felt "drained" and felt he had "heartburn." Claimant ate lunch after leaving the job site. That afternoon, claimant had another heated encounter with a shop steward, and afterward he again felt "drained" and felt he had "heartburn."

Claimant went bowling that evening and drank beer, even though he said he did not feel well. When he got home he ate a sandwich and went to bed. He awoke about 4 a.m. with severe chest pain and his wife took him to the hospital, where a myocardial infarction was diagnosed.

Claimant's treating physician, Dr. Hamilton, stated that he did not believe claimant's work activities were a contributing factor in claimant's myocardial infarction. Dr. Kremkau, who reviewed the medical records at SAIF's request, discussed claimant's prior chest complaints, family history of heart problems, claimant's smoking habit, mild untreated hypertension, obesity and increased cholesterol level. Dr. Kremkau opined that the myocardial infarction occurred as a result of the natural

progression of claimant's atherosclerosis disease, which was related to the above risk factors, and neither the disease nor the infarction were a result of claimant's work activities.

Dr. Girod testified that psychological stress was not nearly as important a factor as was claimant's smoking and cholesterol level. Dr. Girod stated that if claimant had had a large amount of psychological stress directly associated with severe, persistent chest pain that continued for a long period of time, he would have to assume a relationship between the stress and the heart attack. Dr. Girod stated that the facts were against such a relationship here, however, because claimant was able to go bowling after the period of stress and his discomfort seemed relatively intermittent, not prolonged, and not associated with vomiting, sweating or shortness of breath.

Dr. Griswold, on the other hand, testified that claimant's risk factors established a setting for coronary problems, but the occupational stress accelerated the atherosclerosis and the work activities of October 4, 1982 were the immediate precipitating cause of the myocardial infarction.

The Referee rejected the opinions of Drs. Hamilton, Kremkau and Girod because he did not believe those doctors had a complete history of claimant's work activities. Since he found that Dr. Griswold was the only doctor with a complete work history, and since he found Dr. Griswold's explanations convincing, the Referee relied on his opinion and found the claim compensable.

We cannot agree that Dr. Griswold was the only doctor with a complete history. Dr. Hamilton treated claimant for his heart attack and although the record does not contain a report outlining claimant's work history, we think the safer assumption is that Dr. Hamilton, as a treating doctor, knew of claimant's work activities when he opined they did not contribute to the myocardial infarction. Further, Dr. Girod was in the hearing room when Dr. Griswold specifically testified about claimant's work history, so we cannot conclude that Dr. Girod did not know claimant's work history when he gave his opinion. Finally, in this regard, we think that the Referee's rejection of all medical opinion adverse to claimant's position because of incomplete history is somewhat akin to shifting the burden of proof; even if we were able to agree that these adverse opinions were based on an incomplete history, that does not aid claimant in sustaining his burden of proof.

We are more persuaded by Dr. Girod's testimony than by Dr. Griswold's testimony, especially in light of the fact that claimant felt well enough during the day of October 4 to eat and to go bowling after the stressful encounters. It follows that claimant's work activities have not been proven to be a material cause of his myocardial infarction.

ORDER

The Referee's order dated December 22, 1983 is reversed. The SAIF Corporation's denial dated January 9, 1983 is reinstated and affirmed.

ALVIN C. MOREY, Claimant
Jim Scavera, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 83-04275
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Quillinan's order which set aside its denial of claimant's respiratory condition, the primary diagnosis of which is bronchial asthma. The Referee also imposed a penalty and associated attorney's fee for the employer's unreasonably delayed denial, which the employer assigns as additional error. Claimant raises an issue concerning the propriety of the Referee's admission of certain exhibits, which claimant contends were admitted in violation of the 10 day rule. See former OAR 436-83-400(3). In view of our disposition of the compensability issue, it is unnecessary to address this issue. See also Michael Cochran, 35 Van Natta 1726, 1727 (1983).

Our review of the record leads us to two conclusions which are pertinent to the arguments advanced by the employer on the compensability issue. First, this is a claim for an asthmatic condition of long-standing duration, and not merely a claim for a worsening (temporary or otherwise) of that condition on and after November of 1982. Second, a preponderance of the persuasive evidence establishes that this asthmatic condition is compensable as an occupational disease pursuant to ORS 656.802(1)(a). See Dethlefs v. Hyster Co., 295 Or 298 (1983). Accordingly, we affirm this portion of the Referee's order.

With regard to the issue of penalties and attorney fees for the employer's unreasonably delayed denial, we reverse. We agree with the Referee's conclusion that the employer's denial, issued more than four months after this claim was filed, "is a clear violation of the statutory provisions"; however, the record clearly establishes that during this period of delay, claimant had received interim compensation benefits. A 1502 form submitted by the employer indicates that temporary disability compensation was paid from November 30, 1982 through April 15, 1983. The employer denied the claim on April 22, 1983.

Shortly after the Referee's order issued, we decided Ray A. Whitman, 36 Van Natta 160 (1984), in which we found it necessary to reevaluate our prior decisions, particularly Norman J. Gibson, 34 Van Natta 1583 (1982), interpreting the "amounts then due" language of ORS 656.262(10):

> "The Court of Appeals recently reversed that portion of our order in [Eugene Thomas, 35 Van Natta 16 (1983)] which imposed a penalty and attorney's fee, and in so doing, cast considerable doubt upon our interpretation of the 'then due' language in ORS 656.262(10) as expressed in Gibson. EBI Companies v. Thomas, 66 Or App 105 (1983). Although the court's statements appear to be dicta, the clear message is that in situations such as this,

> where the insurer unreasonably delays acceptance or denial of a claim but nevertheless complies with its separate and distinct duty to pay interim compensation during the period of delay, the insurer is not subject to a penalty for unreasonably delaying acceptance or denial pursuant to ORS 656.262(6), because there are no amounts 'then due' upon which a penalty can be assessed within the meaning of ORS 656.262(10). * * * " 36 Van Natta at 161.

In view of the fact that the employer was paying claimant interim compensation benefits during the period of delay, there are no amounts "then due" which can form the basis for imposition of a penalty for the employer's late denial. It follows, therefore, that the Referee's imposition of a penalty and associated attorney's fee must be reversed. See also Darrell W. Carr, 36 Van Natta 16 (1984).

ORDER

The Referee's order dated January 19, 1984 is reversed in part. That portion of the order which imposed a penalty and attorney's fee for the employer's unreasonably delayed denial is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the self-insured employer.

JAN M. MORROW, Claimant
Pippin, Bocci & Shinn, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 82-11471
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's denial of claimant's alleged industrial injury. Claimant has not filed an appellant's brief on Board review. Claimant's request for review does not state the relief to which he believes he is entitled. Presumably claimant's contention is that he sustained a compensable industrial injury on the date in question.

SAIF has submitted a respondent's brief emphasizing the facts that claimant's alleged injury was unwitnessed and that the Referee made an adverse credibility finding. Considering these circumstances, we perceive no error in the Referee's order.

The only issue of consequence is whether SAIF was permitted to retroactively deny this previously accepted claim. See Bauman v. SAIF, 295 Or 788 (1983). There has been an adequate showing of fraud or misrepresentation in this case to warrant the conclusion that the denial in issue is not prohibited by Bauman. See Skinner v. SAIF, 66 Or App 467 (1984); Robert D. Craig, 36 Van Natta 355 (1984); see also Wilkens v. SAIF, 66 Or App 420 (1984).

ORDER

The Referee's order dated September 30, 1983 is affirmed.

NOBLE A. PRICE, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10458 & 80-06188
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests and claimant cross-requests review of Referee McCullough's order which: (1) set aside SAIF's denial of claimant's aggravation claim for a worsened low back condition; (2) awarded claimant compensation for temporary total disability and reclosed the claim pursuant to former OAR 436-83-525; and (3) awarded claimant 96° for 30% unscheduled disability for injury to the low back. SAIF contends that claimant failed to establish a worsening of his injury-related condition, and that claimant has failed to establish his entitlement to an award for permanent partial disability. Claimant contends that it was error for the Referee to reclose the claim because the evidence does not preponderate in favor of concluding that claimant's condition is medically stationary. See ORS 656.005(17). Claimant also contends that he is entitled to a greater award of permanent partial disability.

We agree with the Referee's findings of fact and adopt them as our own. We disagree with the Referee's conclusion that the prior hearing in this matter, held on March 24, 1982, constitutes the last award or arrangement of compensation for purposes of determining whether claimant's condition has worsened. Our decision in Joseph R. Klinsky, 35 Van Natta 332, aff'd without opinion 66 Or App 193 (1983), which formed the basis of the Referee's rationale, is premised on the assumption that there is, in fact, an award of compensation made in connection with the most recent hearing or most recent opportunity to present evidence on the question of extent of disability. The extent of claimant's low back disability was one issue presented during the course of the hearing on March 24, 1982; however, the Referee did not award any permanent disability in view of his conclusions that claimant's heart condition was a compensable consequence of his original injury and that it was necessary to reprocess the claim to closure. See Noble Price, 35 Van Natta 190 (1983); Price v. SAIF, 296 Or 311 (1984) (Supreme Court reversed the Court of Appeals' dismissal of claimant's petition for judicial review and remanded for decision on the merits).

We find and conclude that the last award or arrangement of compensation in this case was the September 5, 1980 Determination Order which originally closed this claim with no award for permanent disability. Considering this Determination Order as the last award or arrangement of compensation, we agree with and affirm that portion of the Referee's order which ordered claim reopening as of July 22, 1982. We are unpersuaded by claimant's argument that the Referee erred in reclosing the claim. On our de novo review, we agree with the Referee's conclusion that claimant was medically stationary as found by the Orthopaedic Consultants in September of 1982.

On the issue of the extent of claimant's permanent disability, we find that claimant is entitled to an award for unscheduled disability in connection with his low back injury, but that the Referee's award is excessive. Based upon the medical

evidence and claimant's testimony, we find that claimant's impairment is in the mild category. He was 46 years of age at the time of hearing. Claimant has obtained his GED and has completed some undergraduate work at a local community college. Claimant is unable to return to his pre-injury employment as a result of his injury, and we find that he has been relegated to performing work essentially in the light category. Although most of claimant's previous employment has involved physical labor and millwork, claimant also has worked as a bread store manager and radio announcer. Considering all of these factors in light of the administrative guidelines provided by OAR 436-65-600 et seq., and comparing this case with other cases involving similarly situated injured workers, we find that an award of 48° for 15% unscheduled disability appropriately compensates claimant for the loss of earning capacity resulting from his low back injury. We modify the Referee's order accordingly.

ORDER

The Referee's order dated September 8, 1983 is modified in part. In lieu of all prior awards of unscheduled disability, including the Referee's award of 96° for 30%, claimant is awarded 48° for 15% unscheduled disability for injury to the low back. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $300 for services on Board review, for prevailing on the issue concerning the compensability of his 1982 aggravation claim.

EDWARD J. QUAYLE, Claimant
Graves & Hilgemann, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-04708
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Baker's order which awarded claimant 80% (256°) unscheduled permanent partial disability, that being an increase of 60% (192°) over and above the April 7, 1983 Determination Order. The issue for review is the extent of claimant's disability.

Claimant, a 35 year old bricklayer, compensably injured his low back on June 18, 1982. An April 7, 1983 Determination Order awarded claimant temporary total disability benefits from June 18, 1982 through March 4, 1983 and 20% (64°) unscheduled permanent partial disability.

Claimant thereafter entered an approved program of vocational rehabilitation. Claimant was to be trained as a building inspector. Although claimant exhibited good motivation, low back and left leg difficulties prevented claimant from completing the program. A second Determination Order issued on September 7, 1983 awarding claimant additional benefits for temporary total disability.

Claimant has been a bricklayer nearly all of his working life. At the time of his injury, claimant was earning over $17.00 per hour. His injury precludes him from returning to work as a bricklayer, or any other heavy labor activities. Although claimant only completed the 9th grade, he obtained his GED in

February 1983 and in many areas, he scored in the the top 19% of the United States average.

Claimant's condition has been described by Dr. Becker as a chronic lumbosacral strain on the left with no findings indicative of nerve root compression. Dr. Becker also reported on March 4, 1983 that claimant's "basic problem" is underlying degenerative disc disease. All of claimant's treatment has been conservative and the neurologic symptoms have been insufficient to warrant surgery. Claimant has been advised by Dr. Becker that he is unable to engage in work involving prolonged stooping, lifting or twisting activity.

It appears that the Referee's award of 80% unscheduled disability was based on the fact that claimant is precluded from his exceptionally high-paying job as a bricklayer. We disagree with this analysis.

The criteria for determining extent of disability resulting from an unscheduled injury is the permanent loss of wage earning capacity. ORS 656.214(5). Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations taking into consideration the claimant's age, education, training, skills and work experience. ORS 656.214(5); Ford v. SAIF, 7 Or App 549 (1972). Loss of income is but one factor considered in determining extent of unscheduled disability. Perry M. Frachiseur, 32 Van Natta 268 (1981); Ford v. SAIF, supra.

Claimant is only 35 years of age. All of his medical treatment has been conservative. As related above, he has received his GED and vocational testing indicates that he is of at least average intelligence. Although precluded from heavy work, claimant is capable of light and probably medium duty work and he does possess transferable skills. Claimant was unable to complete his vocational training program, but hindsight would indicate that the crawling and climbing activities were excessive in view of the restrictions placed on him by Dr. Becker.

Considering the record as a whole, applying the guidelines of OAR 436-65-600 et seq. (including disabling pain), and comparing similar cases, we conclude that claimant would be adequately compensated by an award of 35% unscheduled permanent partial disability.

ORDER

The Referee's order dated October 31, 1983 is modified. Claimant is awarded 35% unscheduled permanent partial disability. This is in lieu of and not in addition to all prior awards. Claimant's attorney's fee should be adjusted accordingly.

EDUARDO YBARRA, Claimant
Doblie, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-02081
July 23, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Daron's order which, in effect, affirmed a Determination Order dated December 10, 1982, which awarded claimant no compensation for permanent disability in addition to previous awards, which total 80° for 25% unscheduled disability for injury to claimant's low back. Claimant contends that he is entitled to an additional award of unscheduled disability.

The insurer has raised a preliminary issue by way of a motion to dismiss this proceeding. The insurer contends that the Board lacks jurisdiction by virtue of claimant's previous withdrawal of his request for review. Although claimant withdrew his request, and an Order of Dismissal was entered accordingly, that order was abated within 30 days, and this proceeding was reinstated. 35 Van Natta 1192, 35 Van Natta 1343 (1983). We conclude that we have jurisdiction to entertain the merits of claimant's request for review. See Lewis Twist, 34 Van Natta 52, 34 Van Natta 290, 293 (1982), affirmed Tektronix Corp. v. Twist, 62 Or App 602 (1983).

On the issue of the extent of claimant's unscheduled low back disability, we do not entirely agree with the Referee's analysis, particularly as it relates to a July 1980 stipulated settlement, which granted claimant an additional 40° for 15% unscheduled disability. The Referee's order states in part:

> "[Claimant's] inability to work in general employment is no different now than it was before claimant entered into the stipulation, insofar as claimant's physical capabilities are concerned. . . . Claimant's age and other attributes indicate that he is not permanent total and that his disability situation, in terms of the impact of his injury on his future earning capacity, is no greater now than it was before the stipulation. Therefore, while claimant may have erroneously agreed upon a figure in July 1980 that was less than what he was really entitled to, he is stuck with it now."

Although it is not entirely clear, it appears that the Referee considered the 1980 stipulation as having some preclusive effect upon claimant's ability to seek an additional award for permanent disability in connection with the December 1982 claim closure. In the interim between the parties' stipulation, which constitutes the last award or arrangement of compensation, and the most recent claim closure in December of 1982, significant low back surgery has been performed as a consequence of claimant's injury. With respect to his physical condition, this constitutes a change of circumstances warranting reevaluation of claimant's permanent disability. James B. Johnson, 35 Van Natta 47 (1983), affirmed Johnson v. Industrial Indemnity, 66 Or App 640 (1984).

The record supports the conclusion that claimant's physical impairment has worsened; nevertheless we agree with the Referee's apparent conclusion that claimant's earning capacity has been significantly enhanced by his completion of an authorized training program in electronics assembly work. We note that this type of employment is within claimant's physical capacity, according to his physician. Considering all of the evidence on our de novo review, we conclude that the Referee reached the correct result, in that claimant's prior awards adequately compensate him for the loss of earning capacity attributable to his industrial injury. Therefore, we affirm.

ORDER

The Referee's order dated June 20, 1983 is affirmed.

ROSEANNE RIDDLE, Claimant
Samuel Hall, Claimant's Attorney
Starr & Vinson, Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-05279 & 82-08058
July 24, 1984
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review (Remanding) dated June 26, 1984.

Claimant argues that she is entitled to an attorney's fee for prevailing on a compensability issue. The only issue raised by the SAIF Corporation in its appellant's brief was premature closure. Accordingly, claimant was not required to discuss compensability in her brief and is not entitled to an attorney's fee for prevailing on that issue on Board review.

Claimant also argues that she should have the right to appeal that portion of the Board's Order on Review which held that the claim was not prematurely closed even though the Board remanded the case to the Hearings Division for rating the extent of claimant's disability. We merely note that Price v. SAIF, 296 Or 311 (1984), upon which claimant relies is cited in our "Notice to All Parties."

On reconsideration, the Board adheres to its former order.

ORDER

The Board's Order on Review (Remanding) dated June 26, 1984 is adhered to and republished this date.

VAN M. BROWN, Claimant
SAIF Corp Legal, Defense Attorney

WCB 83-05313
July 25, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Peterson's order which set aside its denial of claimant's aggravation claim. SAIF argues the aggravation claim is not compensable. We agree and reverse.

Claimant suffered a compensable low back injury in December 1981, for which a laminectomy was performed in January 1982. The

claim was first closed by a Determination Order dated September 23, 1982, which awarded claimant 10% permanent disability. By stipulation dated December 21, 1982, claimant was awarded an additional 15% permanent disability. After termination of his vocational rehabilitation program, another Determination Order issued on February 24, 1983 which awarded no additional permanent disability. We regard the February 24, 1983 Determination Order to be the last award of compensation for purposes of this aggravation claim, but we think the result would be the same if the December 21, 1982 stipulation were regarded to be the last award of compensation.

Dr. Young's chart notes contain an entry which appears to be dated December 11 or 14, 1982. This entry indicates that claimant got out of bed that morning to check some electrical problems in his home, and noted increased back pain when leaning forward to check a breaker box. Dr. Young described the pain as significant and persistent and recommended medication, moist heat, bedrest and that claimant return in one week.

In the next chart note, dated December 20, 1982, Dr. Young states that claimant was slightly better, and recommended beginning exercises. The next chart note, dated December 27, states that claimant had not been able to start his exercises because of continued pain. That chart note also recorded that claimant noticed pain into the left hip area after walking but that he had more range of motion. The next chart note, on January 5, 1983, states that claimant still had about the same amount of discomfort in his back.

Dr. Young's next chart note is dated March 1, 1983 and states that claimant was having no significant improvement of symptoms and was to be admitted to the hospital for traction. Claimant was hospitalized on March 2. Dr. Young's hospital report states that claimant's increasing low back pain "originated at a time when he got out of bed in a hurry to change some electrical apparatus," which we understand in context to be a reference to the events of the prior December 11 or 14.

Dr. Melgard saw claimant in the hospital and reported that shortly before Christmas claimant got out of bed in a hurry and experienced low back pain. Dr. Melgard's impression was that claimant was having recurrent pain. Dr. Melgard later reported that "it is very difficult to nail down an 'objective change', but certainly the patient was having a lot of pain and Dr. Young felt that he should be admitted . . . " Dr. Becker stated that, from an objective standpoint, claimant's condition had not changed.

The Referee found the aggravation compensable on the basis that claimant was hospitalized and the hospitalization itself constituted a worsening that warranted a reopening. Since the Referee's order issued, however, the Court of Appeals ruled in Hutchinson v. Louisiana-Pacific, 67 Or App 577 (1984), that admission to a pain center warrants reopening of a claim only if the claimant establishes a worsening of his condition. We see no material distinction between admission to a residential pain center program and admission to a hospital. It would seem to follow, under Hutchinson, that claimant's hospitalization does not per se warrant claim reopening; and that claimant must otherwise show that his injury-related condition has worsened within the meaning of ORS 656.273.

Several difficult questions could arise in assessing the issue of worsening in this case. Although Drs. Melgard and Becker found no objective change in claimant's condition, Garbutt v. SAIF, 297 Or 148 (1984), seems to hold that no such change need be shown to prevail on an aggravation claim. On the other hand, Scheidemantel v. SAIF, 68 Or App 822 (1984), suggests that just a symptomatic worsening of an injury-related condition is not compensable as an aggravation under ORS 656.273. It appears to us that the implications of Garbutt are somewhat inconsistent with the implications of Scheidemantel.

However, we conclude it is not necessary to consider any questions involving objective change versus symptomatic worsening in this case because the worsening, in any sense of that term, of claimant's condition was before rather than after the last award of compensation. Dr. Young's chart note dated December 11 or 14, 1982 notes claimant's increased back pain when he got out of bed to check an electrical problem. As summarized above, all subsequent reports that comment on the issue identify this early-December incident as the genesis of claimant's distress over the following months. As also stated above, the last award of compensation within the meaning of ORS 656.273 would either be the December 21, 1982 stipulation or the February 24, 1983 Determination Order. If there was any cognizable worsening of claimant's condition, it was before those dates; no worsening, in any sense of that term, is indicated by this record after those dates.

We note that claimant testified at hearing that he had increased back pain when he hurriedly got out of bed to check a breaker box in March 1983. We find, however, that the substantial preponderance of the evidence establishes that claimant was involved in only one get-out-of-bed-to-check-a-breaker-box incident, and that this incident was the morning of December 11 or 14, 1982, just before claimant saw Dr. Young. Claimant's hearing testimony about a March 1983 incident has to be a mistake regarding the date.

ORDER

The Referee's order dated November 10, 1983 is reversed. The SAIF Corporation's denial dated April 26, 1983 is reinstated and affirmed.

HELEN CLEMENT, Claimant
David Force, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-11546
July 25, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Danner's order which: (1) set aside its partial denial of claimant's left-sided carpal tunnel syndrome; (2) awarded claimant an additional 15° (10%) of scheduled disability for partial loss of her right forearm (wrist), on review of a Determination Order dated February 2, 1983, which awarded 22.5° (15%) scheduled disability, thereby granting claimant a total award of 37.5° scheduled disability for 25% loss of use or function of her right forearm (wrist); and (3) imposed a penalty and associated attorney's fee for SAIF's unreasonable denial of claimant's

left-sided carpal tunnel syndrome. On review SAIF contends that the evidence fails to establish the compensability of claimant's left-sided carpal tunnel syndrome; that the Determination Order adequately compensated claimant for the permanent loss of use or function of her right arm/wrist; and that the Referee's imposition of a penalty and attorney's fee is erroneous.

We affirm those portions of the Referee's order concerning the compensability of claimant's left-sided carpal tunnel syndrome and the extent of scheduled disability in connection with claimant's right forearm/wrist. We reverse on the penalty issue.

The facts pertinent to the penalty issue are as follows. Claimant was employed as a fish filleter with this employer for approximately six months when she filed this claim in August of 1981. The 801 form identifies claimant's right hand as the affected body part. Claimant's primary complaint was hand numbness and arm pain on the right side. Her family physician referred her to Dr. Bernstein, a neurologist, for examination. Dr. Bernstein found that claimant's neurologic symptoms were limited to her right upper extremity, and based on his examination and nerve conduction studies, he diagnosed bilateral carpal tunnel syndrome. His report of September 8, 1981 stated: "It should be obvious from the above that her condition is work-related, as carpal tunnel syndrome is endemic among fish filleters." Claimant had previously been employed as a fish filleter for various fish packing plants in the Coos Bay area, prior to her employment herein. SAIF accepted the claim in mid-September 1981.

Dr. Bernstein initiated a course of conservative therapy for treatment of claimant's bilateral carpal tunnel syndrome, the significant symptoms of which were limited to the right side. Because claimant's condition was unresponsive to conservative treatment, Dr. Bernstein referred claimant to Dr. Smith, orthopedic surgeon. He diagnosed carpal tunnel syndrome on the right side, by history and by electrophysiologic criteria and recommended surgical decompression of the median nerve. Claimant submitted to surgery for decompression of the right median nerve in late October 1981. She continued to have difficulty in the right hand post-surgery, and Dr. Smith eventually referred her to Dr. Nathan for further evaluation. After several weeks and a diagnosis of a trigger finger of the right long finger, Dr. Nathan performed trigger release surgery.

Six weeks after this surgery, claimant was examined by Dr. Nathan for follow up. In connection with this examination, Dr. Nathan wrote a September 23, 1982 report to SAIF. He advised that since claimant's right sided carpal tunnel surgery, she had experienced complaints compatible with a carpal tunnel syndrome on the left. Dr. Nathan advised SAIF that claimant was desirous of proceeding with surgery on the left wrist at that time. He advised claimant that, in his opinion, "this would fall under the realm of her private insurance." He further reported his careful explanation to claimant that, "When evidence of impairment is documented bilaterally and that impairment is not noted to have worsened as a result of her employment though symptoms have appeared, it is difficult to document the cause as being work-related."

Claimant returned to see Dr. Bernstein for follow up at the

end of September 1982. He diagnosed left-sided carpal tunnel syndrome and expressed his opinion that the left side should be decompressed. In an October 7, 1982 letter to SAIF, in response to an inquiry, Dr. Bernstein stated:

> "I would thus strongly recommend that you obtain Mrs. Clement's work records. If she indeed did work for about two weeks on or following September 10, then it would certainly be reasonable to consider her left-sided carpal tunnel syndrome industrially related. If she did not, in fact, work during that period of time, of course, there would be no industrial relationship."

In fact, claimant did not work for two weeks on or following September 10, 1982. She worked for one day in September, but was unable to continue this employment.

SAIF denied the compensability of claimant's left-sided carpal tunnel syndrome on November 9, 1982. The Referee found that this denial was unreasonable because SAIF relied upon Dr. Nathan's opinion to the exclusion of all other indications that claimant's left-sided carpal tunnel syndrome was causally related to her employment. The Referee stated:

> "Dr. Nathan's opinion appears to be based on a faulty history, or an incorrect interpretation of the history. His opinion appears to be based on a finding that claimant had no complaints in the left hand until after she had stopped her work activities, and accordingly, that it was the result of a natural aging process. The uncontroverted testimony, however, is that these complaints were concurrent with the original right hand complaints, although of a lesser magnitude, and this is borne out by the original medical reports from Dr. Bernstein, and from claimant's credible testimony, and that of her supervisor."

Because this evidence "existed at the time the denial was published," and SAIF chose to ignore it, the Referee concluded the denial was unreasonable.

In support of the Referee's imposition of a penalty, claimant seems to argue that the claim, from its inception, was for a bilateral carpal tunnel syndrome and, therefore, it was unreasonable for SAIF to deny the compensability of the left-sided component when the symptoms progressed to the point that surgery became necessary. We disagree.

Although the diagnosis of claimant's condition was stated as bilateral carpal tunnel syndrome, the only condition requiring medical attention or resulting in disability at the time the claim was filed was the right-sided carpal tunnel syndrome. Claimant had to stop working because of the symptoms of her right arm. Treatment was rendered in connection with the right arm only.

Claimant submitted to surgery for the right-sided carpal tunnel syndrome only. Although we are satisfied that claimant was, in fact, experiencing left-sided symptoms when her condition was originally diagnosed (which forms the basis for our affirmation of the Referee's compensability determination), we do not believe that the employer or SAIF was aware that compensation was sought for a left-sided condition until Dr. Nathan reported in September of 1982 (more than a year after the claim was originally filed) that claimant's left-sided symptomatology had progressed to the point that she wished to have surgery on that wrist. Up to this point in time, as indicated, the focus was on claimant's right upper extremity, in spite of the diagnosis of bilateral carpal tunnel syndrome.

Based on the information actually available to SAIF at the time of its November 1982 denial, we believe that its denial cannot be fairly characterized as unreasonable. Dr. Nathan had indicated his opinion that claimant's left-sided carpal tunnel syndrome was not related to her employment. Dr. Bernstein had indicated that if claimant had not worked for an approximate period of two weeks on or following September 10, 1982, "of course, there would be no industrial relationship." Although Dr. Bernstein subsequently quite clearly expressed his opinion that claimant's left-sided carpal tunnel syndrome was related to her employment exposure, his statement in October of 1982 (in light of claimant's actual work records) rather strongly suggested that claimant's left-sided symptoms were not compensable. Under these circumstances, we believe that SAIF's denial was not unreasonable. See also Ginter v. Woodburn United Methodist Church, 62 Or App 118, 122 (1983) (denial not considered unreasonable in light of medical evidence available at time of denial); Charles M. Schwab, 36 Van Natta 333 (1984) (medical reports in insurer's possession at the time of denial indicated that claimant had been experiencing similar medical problem for a significant period of time preceding filing of claim); Linda L. Logan, 36 Van Natta 110, 112 (1984) (based on the information available at the time its denial was issued, the insurer had a reasonable belief that claimant's worsened condition was not related to original industrial injury).

ORDER

The Referee's order dated January 31, 1984 is reversed in part. That portion which imposed a penalty and associated attorney's fee for unreasonable denial is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $450 for services on Board review, to be paid by the SAIF Corporation.

EUGENE L. COLE, Claimant
Levi J. Smith, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-05413
July 25, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Pferdner's order which upheld the SAIF Corporation's denial of claimant's aggravation claim.

Claimant argues "his claim should be reopened for a redetermination of the extent of his permanent disability." That sounds like a collateral attack on the last award of compensation,

which is prohibited by Deaton v. SAIF, 33 Or App 261 (1981) -- an impression that is reinforced by the fact that no doctor has suggested any curative treatment for claimant's allegedly worsened condition, with the prospect of curative treatment being the most common basis for claim reopening. Thus, although we do not agree with some portions of the Referee's analysis, we agree with the Referee's ultimate conclusion.

ORDER

The Referee's order dated January 5, 1984 is affirmed.

'DICK A. COMSTOCK, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 82-07496
July 25, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer, International Paper Company (IP), requests review of Referee Foster's order which: (1) ordered the employer to pay claimant temporary disability benefits from the date of injury until the claim is closed pursuant to ORS 656.268, less time worked; and (2) set aside IP's denial of aggravation, finding that claimant's worsened cervical condition is IP's responsibility pursuant to the rule found in Grable v. Weyerhaeuser Co., 291 Or 387 (1981).

IP contends that the last injurious exposure rule set out in Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984), contains the rule applicable to this case and that, under that rule, it is not responsible for claimant's worsened cervical condition.

In Grable v. Weyerhaeuser Co., supra, a worker suffered an on-the-job back injury and his employer accepted the claim. After the worker returned to work, he reinjured his back at home and made a claim against his employer claiming that the worsening of his back problems resulted from the on-the-job injury. The court held that, under ORS 656.273(1), if the worker establishes that the on-the-job injury is a material contributing cause of the worsened condition, the employer is liable for the payment of compensation benefits even if the off-the-job injury was also a material contributing cause.

The courts have made a different rule for shifting responsibility when the injurious exposure which causes the disability occurred during successive employments. This test is called the last injurious exposure rule and liability shifts when a later employment actually contributes to the cause of the disability. Boise Cascade v. Starbuck, 296 Or 238 (1984).

In this case, claimant originally injured his neck in May 1981 while working for IP. When claimant was ready to return to work in August 1981, he was laid off along with other employees. He then went into business for himself as an electrical contractor and continued in his business from August 1981 through December 1982, when he could no longer work due to his worsened neck condition. During the same period, he had been temporarily called back to IP on approximately four different occasions. The medical opinion in this case was that, while the main cause of the claimant's worsened neck condition was due to the injury at IP, claimant's work as an independent electrical contractor also

materially contributed, in at least a small way, to the worsened condition.

Claimant did not have workers' compensation coverage while he was working in his own business. The Referee determined that the test found in Grable v. Weyerhaeuser, supra, therefore, was the applicable rule because "exposure which occurs at work when the worker does not have workers' compensation coverage, should be treated as an off-the-job exposure."

The facts of Peterson v. Eugene F. Burrill Lumber, 57 Or App 476 (1982), affirmed 294 Or 537 (1983), are very close to the case before us. In Peterson, the claimant sustained an on-the-job back injury and received an unscheduled permanent partial disability award. His back condition deteriorated in later years during which the worker was self-employed in an occupation involving bending and lifting. The claimant was not covered by workers' compensation insurance during his self-employment. The Court of Appeals determined that to establish a compensable aggravation claim, the applicable test was that found in Grable v. Weyerhaeuser Co., supra, rather than the last injurious exposure rule. Therefore, to prove a compensable aggravation claim the claimant need only show that his worsened condition "resulted" in a material way from the original injury and that, where the worsening was a result of both the compensable on-the-job back injury and the subsequent self-employment exposure, the worker has established a compensable aggravation claim against the original employer. The Court of Appeals made the following comment regarding their application of Grable:

> "The present case is not the type of off-the-job injury case presented in Lemons [v. Compensation Department, 2 Or App 128 (1970)] (off-the-job fall), Standley [v. SAIF, 8 Or App 429 (1972)] (off-the-job incident injuring the low back), and Christensen [v. SAIF, 27 Or App 595 (1976)] (slip and fall in bath tub). Nor does the present case involve the issue of which of two workers' compensation insurers should be liable for a later injury. See Smith v. Ed's Pancake House, 27 Or App 361, 556 P2d 158 (1976) ('last injurious exposure' rule); Grable v. Weyerhaeuser Co., supra, 291 Or at 401-402.
>
> "In the present case, the later injury, strictly speaking, occurred on the job; however, claimant had not elected to be covered by workers' compensation. Therefore, claimant's position is analogous to the Lemons, Standley and Christensen situations, and the question is whether the prior on-the-job injury is a "material contributing cause" of the claimant's worsened condition at the time he filed his claim for aggravation." 57 Or App at 478 n 1, quoted at 294 Or 542 n 4.

The Supreme Court granted review of the Court of Appeals'

decision "to decide whether the rule of Grable applies to a worsening occurring while claimant is self-employed and whether the last injurious exposure rule is applicable." 294 Or 537, 539.

However, in its written opinion the Supreme Court determined it did not have to reach that issue because its review of the facts found there was no material contributing exposure from the claimant's self-employment and, therefore, they declined to express an opinion as to the correctness of the applicability of Grable to the facts before them.

We are left, then, with the Court of Appeals' opinion which held that the test found in Grable is the proper test for cases such as that now before us. The Supreme Court's opinion did not reverse or modify that holding. Therefore, because claimant has proved that the original, compensable injury which occurred while employed at IP is a material contributing cause of his present worsened condition, he has proved a compensable aggravation claim against IP, even though his subsequent work as an electrical contractor also contributed to that condition.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated December 9, 1983 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by International Paper Co.

HOWARD E. DEAKIN, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-02773
July 25, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Leahy's order which: (1) awarded 60% (192°) unscheduled permanent disability in lieu of the 30% (96°) permanent disability awarded by the Determination Order; (2) upheld the SAIF Corporation's denial of claimant's carpal tunnel syndrome; and (3) upheld SAIF's denial of claimant's left ankle fracture. Claimant contends that he is permanently and totally disabled and that the carpal tunnel syndrome and the left ankle fracture are compensable.

The Board affirms the Referee's permanent partial disability award and that part of the order upholding SAIF's denial of claimant's carpal tunnel syndrome. However, the Board finds the left ankle fracture compensable.

Claimant suffered a compensable neck and head injury in September 1979. He reported that he was having problems with dizziness, stumbling and falling in March 1980. In May 1980 claimant fell, fracturing his left ankle. Dr. Rafal, who treated claimant for his neck injury, stated that claimant's balance problems were related to his neck injury and had caused claimant to fall. Consequently, Dr. Rafal believed that the ankle fracture was related to claimant's compensable neck injury. A panel of doctors at Orthopaedic Consultants also related claimant's balance problems to his industrial injury. The record contains no explanation for claimant's balance problems other than his neck injury.

Therefore, we find that claimant's left ankle injury is compensable. We agree with the Referee, however, that claimant has not proven any permanent impairment of the left ankle.

ORDER

The Referee's order dated January 26, 1984 is affirmed in part and reversed in part. The SAIF Corporation's March 23, 1981 denial of claimant's left ankle injury is set aside and that claim is remanded to SAIF for acceptance. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services at hearing and $300 for services on Board review related to the left ankle claim.

WILLARD ELLIS, Claimant
Davis, et al., Claimant's Attorneys
Keith Skelton, Defense Attorney

WCB 82-10518
July 25, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of those portions of Referee Brown's order which: (1) concluded that claimant was not entitled to reimbursement for the cost of traveling from Ashland to Eugene for chiropractic treatments; (2) declined to award a penalty and related attorney's fee for unreasonable resistance to payment of compensation in the form of said travel expenses; and (3) awarded claimant's attorney a fee, for prevailing on the insurer's partial denial of further chiropractic treatment, that was payable out of claimant's compensation rather than insurer-paid. The insurer raises an additional issue, arguing that the Referee erred in setting aside its partial denial of further chiropractic treatments.

In December 1973 claimant compensably injured his back when he slipped and fell on a spot of oil. The injury was diagnosed at that time as a strain. Claimant also has preexisting rheumatoid arthritis, dating back to about 1954. Chart notes from Dr. Reynolds, who treated claimant's arthritis beginning in the 1950s, document that claimant's rheumatoid arthritis affected his upper lumbar and mid thoracic spine as early as 1959. In May 1975 claimant received a stipulated award for 15% unscheduled disability as a result of the 1973 industrial injury.

Claimant has received regular chiropractic treatments since his 1973 back injury. In April 1981 claimant began seeing Dr. Scolfield, a chiropractor in Eugene. Dr. Scolfield uses a spring loaded device known as a "Pettibon instrument" which, according to claimant's testimony, the doctor presses on the mastoid cavity below claimant's ear; this procedure, according to claimant's testimony, somehow relieves the pain in his thoracic spine. The insurer paid for these treatments until February 28, 1983 when it issued its partial denial of further treatment here in issue. The insurer never paid claimant for mileage expenses for traveling from his home in Ashland to Dr. Scolfield's office in Eugene for the treatments.

The Referee set aside the insurer's denial. He found, however, that there was like treatment available in the Ashland area and, based on OAR 436-54-245(4), concluded that the insurer was not liable for claimant's travel expenses. The Referee

awarded claimant an attorney's fee of $1,000 payable out of compensation.

We disagree with the Referee on the compensability issue, which makes it unnecessary to consider the other issues in depth.

In April 1983 Dr. Weinman, an orthopedist, examined claimant and opined:

> "The contusion that he suffered in his back on 12-11-73, should have been healed by three months after the accident, and I don't think is responsible for his continuing back pain. . . . [I]t is quite possible that his continued thoracic back pain over the paravertebral muscles is more probably due to his rheumatoid disease than it is to the injury of 12-11-73."

In July 1983 Dr. Rosenbaum, a rheumatologist, examined claimant and opined:

> "At this time I find no evidence of any condition that I can relate to the injuries that the patient has described. If there is any cause of his symptoms, it would be directly related to his rheumatoid arthritis, which would not be work related.
>
> * * *
>
> "At this time, I find no evidence of any work related injury, and certainly no condition that I can reasonably attribute to an industrial injury in December of 1973. As for ongoing chiropractic treatments, I do not feel that this is at all related to the patient's injury and my only comment is that I seriously question any treatment that goes on for years without termination of the illness."

In November 1983 Dr. Emori, a rheumatologist, examined claimant. He questioned Dr. Rosenbaum's opinion because "rheumatoid arthritis rarely, if ever, involves the spine, other than in the neck. Involvement in the mid back in not consistent with rheumatoid arthritis." Dr. Emori concluded that claimant's "back discomfort is more consistent with injury than with inflammatory disease."

We find the opinions and explanations of Drs. Weinman and Rosenbaum more persuasive than Dr. Emori's analysis. It may be, as Dr. Emori says, unusual for rheumatoid arthritis problems to involve the mid back, but that is exactly what Dr. Reynolds' chart notes say he was treating as long ago as the 1950s, and is exactly what Drs. Weinman and Rosenbaum say is now being treated. We therefore reverse the Referee on the compensability issue.

We affirm and adopt those portions of the Referee's order on the issue of reimbursement for travel expenses. We agree with the

Referee's finding of fact that like treatment is available in the Ashland area. OAR 436-54-245(4) provides that, if like treatment is available in the geographic area where a claimant resides, he is not entitled to mileage reimbursment for travel to another area for that treatment. In SAIF v. Holston, 63 Or App 348 (1983), the court noted, but did not decide, the question of whether that rule is valid. We assume that it is.

Although the attorney fee issue is mooted by our disposition of the compensability issue, we note that the Referee erred in awarding claimant's attorney a fee to be paid from claimant's compensation. Claimant prevailed at hearing on the insurer's denial. Attorney fees for prevailing on a denial should be awarded in addition to compensation, rather than out of compensation.

We also note that claimant is not entitled to any penalty or associated attorney's fee for unreasonable resistance to the payment of compensation.

ORDER

The Referee's order dated January 5, 1984 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the insurer's partial denial of further chiropratic care is reversed, and the insurer's partial denial is reinstated and affirmed. Those portions of the Referee's order which found that the insurer is not liable for travel expense reimbursement and which declined to assess a penalty are affirmed.

ERMA L. PARMER, Claimant
Pozzi, et al., Claimant's Attorneys
David Horne, Defense Attorney

WCB 82-05555
July 25, 1984
Order on Reconsideration

The Board issued its Order on Review herein, 35 Van Natta 830 (1983), and claimant thereafter requested reconsideration, moving the Board for an order remanding to the Referee for further evidence taking, ORS 656.295(5). In order to allow an adequate opportunity for consideration of claimant's request and the insurer's response thereto, we abated our Order on Review. 35 Van Natta 1082 (1983). On reconsideration, we supplement our prior order and, except as supplemented, adhere thereto.

The issue at hearing was the compensability of an elective surgical procedure first recommended by claimant's treating orthopedic physician, Dr. Berselli, in February of 1982. Dr. Silver, neurosurgeon, subsequently concurred in the need for surgery. After referring claimant for examination by Dr. Rosenbaum, neurologist, the insurer denied authorization for the surgery. The denial letter, dated June 18, 1982, states in part, "Our denial of surgical treatment is based on the fact that it does not appear that your need for surgery arises out of any condition arising out of and in the course of employment, either by accident or occupation [sic] disease . . . ."

Hearing convened on September 9, 1982, the primary issue being "whether or not the surgery should be authorized." Counsel for the insurer stated that the reasonableness of the proposed surgery, as well as its causal relationship to claimant's accepted

December 1981 industrial injury were in issue. In addition to the testimony of claimant and her husband, the testimony of three physicians was taken: Dr. Berselli, Dr. Rosenbaum and Dr. Bachhuber. Dr. Bachhuber is claimant's former orthopedic physician, who performed a partial L5-S1 laminectomy in 1969 and continued to treat claimant until June of 1980.

The Referee upheld the insurer's denial based upon his conclusion that a preponderance of the evidence failed to establish that the surgery proposed by Dr. Berselli was reasonable and necessary. On our review of the Referee's order, we agreed with his conclusion that the surgery is not compensable; however, we stated our unwillingness "to decide the medical services question in this case on the ground that the proposed surgery is not necessary." We stated that the evidence "militates in favor of a finding that the surgery is reasonable," but concluded that the evidence also preponderates in favor of concluding that the surgery is not necessary as a result of claimant's 1981 injury. Viewing Dr. Berselli's testimony in a light most favorable to claimant, we concluded that his testimony in support of the need for surgery established that the condition requiring surgery was more likely attributable to the residua of claimant's 1968 injury and ensuing surgery, in the form of scar tissue impinging upon a nerve root. We stated:

> "In so holding, we are aware that Dr. Berselli also testified that the 1981 injuries materially contributed to claimant's present condition. However, he also made it clear that the contribution was in the form of making symptomatic the nerve impingment already existing as a result of the scarring. Dr. Berselli testified that it was possible that the 1981 injury caused bleeding and further scarring at the site of the previous surgery and/or caused a small disc herniation at the same site. However, he could not testify that these events probably happened; they were at best contingencies until such time as claimant undergoes surgery and it can be determined what actually has happened internally to the nerve roots at L5-S1.
>
> "Since the scarring condition is an underlying preexisting condition, claimant is required to prove that the injury of November and December 1981 caused a pathological worsening of that underlying condition. [Citations omitted.] Dr. Berselli's testimony is too weak to enable us to make such a finding; therefore, we agree with the Referee that the insurer's denial must be upheld." 35 Van Natta at 838.

I

We issued our Order on Review on June 27, 1983. On July 14,

1983, we received claimant's request for reconsideration, indicating that claimant had undergone the surgery in question on March 7, 1983. Attached to and in support of claimant's request are copies of the operative report, a June 24, 1983 report from Dr. Berselli, copies of Dr. Berselli's office notes, and a report from Dr. Silver dated March 23, 1983. Claimant seeks an order remanding to the Referee for inclusion and consideration of this additional evidentiary material.

We have authority to remand a case to a Referee for further evidence taking, correction or other necessary action in the event that we determine a case has been "improperly, imcompletely or otherwise insufficiently developed or heard by the Referee." ORS 656.295(5). Our review of some recent authorities in which remand was considered an appropriate disposition leads us to conclude that claimant's motion should be denied because this case has not been "improperly, incompletely or otherwise insufficiently developed."

In Edith Grimshaw, 36 Van Natta 63 (1984), we found remand appropriate where, during the time that claimant's request for Board review of an adverse Referee's decision was being processed, claimant sought further medical evaluation of her condition from a new physician who, for the first time, decided that claimant should undergo a CAT scan. This diagnostic procedure disclosed an obvious herniated disc at the L4-L5 level of claimant's spine which, in the physician's opinion, required surgery and was related to claimant's accepted industrial injury. At the time of hearing, the medical evidence indicated that claimant's condition was more likely due to progression of her preexisting osteoarthritis, rather than her industrial injury, although a chiropractic physician had stated that, in his opinion, claimant's 1978 back strain had never healed. We determined that this case involved "a claimant who had never obtained a satisfactory explanation of the cause of her medical condition, who continued to seek an explanation and who was finally rewarded for her diligence with an objective medical explanation of the problem." 36 Van Natta at 64.

In Ronald J. Gazeley, 36 Van Natta 212 (1984), we determined it was appropriate to remand where, within days after his hearing, claimant visited a new physician who ordered a CAT scan for the first time, which disclosed a central herniated disc at the L4-L5 level of claimant's spine. Claimant was thereafter referred to a new neurologist, who ordered a myelogram to ascertain the presence of lumbar stenosis and disc protrusion. With the benefit of these additional diagnostic tests, claimant's new neurologist indicated that claimant was suffering from a recurrent protruded disc which was related to his accepted 1975 industrial injury and subsequent lumbar laminectomy. The Referee had upheld the insurer's denial of claimant's aggravation claim, primarily for the reason that, at the time of hearing, there was insufficient objective evidence of a worsened condition to substantiate claimant's subjective complaints. We remanded to the Referee for consideration of this additional evidence of objective findings.

In both Grimshaw and Gazeley we relied upon Egge v. Nu-Steel, 57 Or App 327 (1982), in making the determination that remand was an appropriate disposition. Egge was an extent of disability case in which claimant's Oregon physicians had failed to diagnose any

objective cause for his low back pain. Claimant had informed one physician that he would continue to seek medical attention until the cause of his pain was identified. One month before his hearing, claimant moved to Washington. He saw a physician in Washington who, the day after the Referee's order was entered, reported that x-rays disclosed a hairline vertebral fracture at the L1 level of claimant's spine. The court remanded to the Referee for reconsideration in light of this additional evidentiary material. See ORS 656.298(6).

In Bailey v. SAIF, 296 Or 41 (1983), the Supreme Court reviewed our policy concerning requests for remand as expressed by our decision in Robert Barnett, 31 Van Natta 172 (1981). After reviewing our Barnett decision, in the context of claimant's request for remand in Bailey (which we had denied), the court stated:

> "The Workers' Compensation Board has chosen to limit remands on the basis of 'newly discovered evidence' to cases where there is a showing that the evidence 'could not reasonably have been discovered and produced at the hearing' and, further, 'to merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing.' We agree that the rule is permissible for remands for 'newly discovered evidence.' However, the Board has not articulated rules for myriad other situations in which a case may be 'improperly, incompletely or otherwise insufficiently developed or heard' under ORS 656.295(5)." 296 Or at 48-49.

The court held that Bailey did not involve a request for remand on the basis of "newly discovered evidence"; rather, that case dealt with a potentially incompletely developed record. The court remanded to the Board to determine whether the case had been "improperly, incompletely or otherwise insufficiently developed or heard by the Referee."

On our further review of Bailey on remand, we determined that the record had been insufficiently developed and that remand, therefore, was appropriate. Catherine C. Bailey, 36 Van Natta 280 (1984). We noted that, at the time of hearing, the medical evidence indicated that claimant was suffering from sarcoidosis, a disease not related to her employment or industrial exposure. Claimant, who had been unrepresented at the hearing, had presented no evidence concerning the nature of her alleged industrial exposure. The additional evidentiary material which formed the basis of claimant's request for remand included a report from a physician who previously diagnosed sarcoidosis, but who, apparently, was desirous of withholding his opinion until he was able to see additional medical reports, medical studies and information regarding chemicals to which claimant was exposed at work. Other reports indicated that claimant's work exposure caused her respiratory condition. In finding that remand was appropriate, we stated: "The medical reports do not indicate that the doctors had the benefit of information regarding the chemicals to which claimant was exposed and the toxicity of those chemicals,

except what claimant told them, in rendering their opinions. Also, the sarcoidosis diagnosis may need to be reevaluated by the reporting doctors in light of findings reported after the hearing." 36 Van Natta at 281.

The facts of this case, and the background against which we must consider claimant's request for remand, are significantly different from the facts of all the above-referenced cases in which the Board or the court found remand to be an appropriate disposition. The issue in this case is whether the insurer should be required to pay for surgery in connection with claimant's low back condition. Its denial raised issues concerning the causal connection between claimant's industrial injury and the surgery recommended by Dr. Berselli, as well as questions concerning the reasonableness and necessity of the surgery. In support of her contention that surgery was reasonable and necessary as a result of her 1981 injury, at the hearing claimant relied primarily upon the testimony of Dr. Berselli and statements from Dr. Silver. These are the same physicians whose opinion claimant now relies upon in support of her request for remand. Since the hearing, these physicians have had the benefit of performing surgery and, therefore, viewing the condition of claimant's spine at the time of surgery in March of 1983. Dr. Berselli's recent report states in part:

> "I believe that her work injury of December 3, 1981 was indeed a materially contributing factor to her need for further medical care. I base my opinion on the fact that the patient required a decompressive laminectomy and spinal fusion in order to achieve maximum recovery benefits.
>
> "* * * I believe that the December, 1981 injury caused some increase in epidural scarring in her spinal canal. This scarring was found at the time of her decompressive laminectomy."

Dr. Berselli, essentially, has in his most recent post-surgical report reiterated his prior opinion that claimant's December 1981 injury materially contributes to the need for surgery. He also states his belief that claimant's 1981 injury caused an increase in scar tissue formation, which was found at surgery.

On the question which we found determinative on review -- the causation question -- the additional evidence proffered by claimant adds little or nothing. Having had the benefit of viewing the condition of claimant's spine on surgery, we would expect Dr. Berselli to be in a position to offer a better explanation of his findings and how those findings support his conclusion that the epidural scarring in claimant's spinal canal was caused in material part by her 1981 industrial injury, as opposed to her 1969 low back surgery. As we read Dr. Berselli's most recent report, it merely states the finding of epidural scarring in the spinal canal and his "belief" that claimant's 1981 injury caused some increase, with no explanation in support of this belief. This was one of the two theories advanced by Dr. Berselli at the hearing, and his recent post-surgical report adds little in support of this theory.

Unlike those cases in which we have found remand appropriate, this case does not present a record which has been incompletely or insufficiently developed on the question of the compensability of the surgery proposed by Dr. Berselli in February of 1982 and ultimately performed in March of 1983. A new diagnosis has not been presented, one which evaded physicians before surgery was finally performed. As this case has developed, it appears that it may have been more propitious for claimant to proceed with surgery before the hearing, in which case the evidence of surgical findings would have been available to the Referee. Be that as it may, the fact that surgery now has been performed does not, under the facts and circumstances presented herein, persuade us that remand is warranted. See also Armstrong v. SAIF, 67 Or App 498, 502-03 (1984).

II

In the interim since our Order on Review, the law concerning the compensability of a worsened, preexisting condition has been somewhat clarified, as it relates to industrial injury claims. As the above-quoted portion of our Order on Review reflects, there was some uncertainty concerning the compensability of an injury superimposed upon a preexisting condition, where the evidence established only a worsening of the symptoms of the condition, as opposed to a worsening of the underlying pathology. Since our Order on Review, the Court of Appeals has decided that the requirements of Weller v. Union Carbide, 288 Or 27 (1979), apply only in claims for occupational disease. Jameson v. SAIF, 63 Or App 553 (1983); Boise Cascade v. Wattenbarger, 63 Or App 447 (1983). We have recognized, however, that an injury which produces symptoms of a preexisting, underlying condition may only obligate the insurer to pay for the symptomatic worsening, without rendering the underlying condition itself compensable. Betty L. Counts, 35 Van Natta 1356 (1983), 36 Van Natta 18 (1984); Roy L. Bier, 35 Van Natta 1825 (1983). See also Jose G. Perez, 36 Van Natta 720 (1984) (injury resulted in onset of symptoms of underlying condition, ankylosing spondylitis, without causing a pathological change and without contributing to the further, continued progression of that disease process).

To the extent that the conclusions expressed in our Order on Review were premised upon the symptoms/underlying condition dichotomy of Weller v. Union Carbide, supra, a clarification is in order in view of more recent developments in the law. The issue before us is the compensability of the surgery proposed by Dr. Berselli. For the reasons stated in our Order on Review, it appears that surgery may be a reasonable and necessary form of treatment. Our review of the evidence of record fails to persuade us that it is medically probable that claimant's 1981 injury is a material contributing cause of the condition requiring the surgical intervention proposed by Dr. Berselli. For this reason, we agree with the Referee that the insurer's denial was proper.

ORDER

On reconsideration of our Order on Review dated June 27, 1983, we supplement our prior order as provided herein. Except as supplemented, we adhere to our prior order, which hereby is readopted and republished.

RANDAL R. SENNER, Claimant
Haas & Benziger, Claimant's Attorneys
Miller, et al., Defense Attorneys
Moscato & Byerly, Defense Attorneys

WCB 82-05948, 82-06563 & 83-01044
July 25, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Consolidated Freightways requests review of Referee Galton's order which: (1) set aside its denial of claimant's 1979 claim for a right shoulder injury; (2) set aside its denial of claimant's aggravation claim for his right shoulder; (3) affirmed Freightliner's denial of claimant's new injury claim; and (4) assessed it penalties and accompanying attorney fees for an unreasonable delay in denying the 1979 claim, as well as for an unreasonable denial. On review, the issues are compensability, responsibility and whether the penalties and attorney fees were justified.

Claimant was 33 years old at the time of hearing. He worked for Consolidated Metco from October 1968 until May 1982. Consolidated Metco's workers' compensation claims were administered by Consolidated Freightways until August 1, 1981. Thereafter, Freightliner administered Consolidated Metco's claims.

Claimant testified that on April 2, 1979, while lifting a "Hub-37" as a production set-up operator, he felt a burning-tearing sensation in his right shoulder. He stated that he immediately advised his supervisor, executed a Form 801, obtained his supervisor's signature and received his "worker's receipt." At hearing, claimant produced a partially completed "worker's receipt" of a Form 801, dated April 2, 1979, bearing the purported signature of claimant's supervisor, Don Sylvester. The form's authorization for release of medical information was unsigned and the employer's name and address was not filled in.

Claimant had sustained approximately six compensable industrial injuries prior to the alleged 1979 incident, only two of which were disabling. Claimant admitted that occasionally workers took a Form 801 home to fill out and never filed it. Further, if claimant hurt himself, but felt he could continue working, he might verbally report the incident to his supervisor, but refrain from filing a Form 801. However, he was sure he "turned in a claim form in 1979 for my right shoulder."

Consolidated Freightways had no record of claimant's 1979 claim. Ms. Dwinell, claims examiner, testified that the standard operating procedure was to return an incomplete Form 801 to the worker or request that he come to the office to provide further information. It was her opinion that the form could have been partially completed by claimant, signed by his supervisor and retained by claimant, without filing it. Ms. Dwinell testified that if this claim actually did become lost in the processing system, it would be the first time in her five years of claims processing.

Claimant missed no time from work following this alleged April 1979 incident. He testified that he sought medical treatment within a few days from Dr. Reichle, family practitioner. Dr. Reichle's records indicate claimant was examined on July 20, 1979 regarding a "lump" in his right

shoulder. Dr. Reichle had previously examined claimant on April 30 and May 7. These examinations concerned a motorcycle accident while trail riding in which claimant complained of a left foot, ankle and leg injury. There were no references to right shoulder problems on these dates.

Claimant's July 1979 medical history indicated that claimant had noticed the lump for the past 6 to 12 months. Claimant complained of soreness radiating into his neck, which worsened when claimant was consuming alcohol. There was no reference to claimant's work activities. Dr. Reichle diagnosed tenderness of the right sternomastoid and muscle spasms. He referred claimant to physical therapy. Claimant received two treatments on July 24 and 26. After returning to Dr. Reichle on February 7, 1980, claimant was instructed to return for therapy on an as needed basis. Although claimant sought medical attention for a variety of maladies on several subsequent occasions, he received no further treatment for his right shoulder until May 1982.

Ms. Pedro, collection manager for the clinic at which Dr. Reichle practiced, testified that claimant's July 1979 billing was processed through his private insurer. She testified that if there had been a request to treat the injury as industrial, she would have prepared a Form 827.

Claimant testified that he probably claimed Dr. Reichle's bill through his private insurer. He also did not believe he followed up on his 801 claim. Although claimant had filed approximately six prior compensable claims, he apparently felt that in order to be eligible for compensation and medical benefits a worker would have to miss time from work.

On January 28, 1980 claimant sustained a compensable left shoulder injury. He was again examined by Dr. Reichle, who diagnosed acute muscle strain of the left scapula and prescribed physical therapy. The claim was closed by Determination Order dated April 9, 1980. Claimant was awarded no temporary or permanent disability. The order was not appealed.

Claimant testified that the "lump" in his right shoulder never entirely went away. The pain would fluctuate, depending on his work activity. Whenever possible, claimant would favor his right arm and shoulder. Beginning in February 1982, claimant's work activities changed. Due to personnel cutbacks, claimant was assigned full-time duties in the assembly area. This work involved a great deal of lifting, stacking, and overhead use of his right shoulder and arm. His pain symptoms gradually increased. Claimant testified that he did not sustain any off the job injuries or engage in any non-work activities which could have been responsible for his increase in symptomatology in 1982.

The recurrent pain in claimant's right shoulder increased to the point that he sought treatment on May 10, 1982. Claimant was examined by Dr. Harvey, who had replaced the retired Dr. Reichle. At the examination claimant reported that he was experiencing a recurrence of his right shoulder injury of February 1, 1980. Dr. Harvey diagnosed chronic thoracic strain with myofascitis, prescribed therapy and authorized time loss. Dr. Harvey forwarded a Form 827 to Consolidated Freightways describing the nature of the injury as "reacurrence [sic] of injury on 2-1-80 right shoulder area."

Claimant received physical therapy on May 12, 1982. Thereafter, he traveled to his family's property, near the Canadian border, where he remained for approximately two weeks. During his stay he and another person planted approximately two thousand seedling trees. On May 24, claimant returned to Dr. Harvey whom reported claimant's right shoulder condition as unchanged. On June 4 Dr. Harvey reported an improvement, prescribed continued physical therapy and advised claimant to return in two weeks.

On June 3, 1982 claimant advised Ms. Dwinell, of Consolidated Freightways, that he sustained no specific new injury. However, his continuous, steady and heavy work activities had caused the symptoms from his February 1, 1980 "right shoulder" injury to really start hurting again. After reviewing the 1980 "left shoulder" claim, Ms. Dwinell issued a denial, on behalf of Consolidated Freightways, of the "right shoulder" aggravation claim. This denial was not appealed.

After receiving the denial, claimant advised Ms. Dwinell that he had intended to reopen his 1979 claim. Ms. Dwinell replied that no such claim was on file. On June 7 claimant met with Ms. Dwinell and showed her his "worker's receipt" of Form 801 which concerned the purported April 1979 right shoulder claim. That same day Ms. Dwinell, on behalf of Consolidated Freightways, issued claimant a check for time loss between May 10 and June 4.

On June 8 claimant executed a Form 801 alleging pain and swelling in his right shoulder "possibly related to working in Hub assembly." He indicated the date of injury or diagnosis was February 1, 1982. By letter of June 11, Freightliner denied responsibility.

On July 12 Ms. Dwinell prepared a Form 801 for claimant indicating the date of claimant's right shoulder injury was April 2, 1979. By letter dated July 12 Consolidated Freightways denied the 1979 injury and denied claimant's aggravation claim.

Dr. Harvey referred claimant to Dr. Eckhardt, orthopedist. On August 10 Dr. Eckhardt opined that claimant had a mild to moderate myositis involving the right upper back and neck, with "perhaps" a mild synovitis of the right shoulder and "maybe" a mild bicipital tendinitis of the left shoulder. The doctor prescribed deep heat massage therapy, medication and "probably" a home exercise program in two weeks.

On August 20 claimant applied for and received non-occupational disability benefits from the Machinist's Trust. Ms. Erb, a representative of the administrator for the Trust, testified that she advised claimant that if he was successful in his appeal, he would be obligated to reimburse the Trust for the benefits it had provided to him.

By letter dated January 20, 1983, Consolidated Freightways' attorney set out his understanding of Dr. Harvey's opinion and requested the doctor's comments. With a number of corrections and interlineations, Dr. Harvey concurred with the attorney's statements. In what appears to be his own handwriting, Dr. Harvey opined that he could not, "within medical probability, express an opinion that there is any cause and effect relationship between

[claimant's right shoulder] symptomatology in 1979 and that in 1982." He termed the relationship as "possible" only.

Dr. Harvey further concurred with the statement that:

> "[T]hese [right shoulder] problems were reported by [claimant] to have been present for '6-12 months' [at the time of his July 20, 1979 visit]. No history was taken that indicated that these shoulder problems were industrial in origin or that they occurred while [claimant] was on the job for any employer.
>
> "Further, based solely upon the history taken from [claimant], if taken as true, as well as subjective signs and symptoms, if they are to be taken as legitimate, his work activities in 1982 as he reported them to you have independently contributed to his condition and have aggravated and worsened it inasmuch as these activities have created a burning pain and tightness sharper than previously reported in 1979...
>
> "[However], as your findings are based solely upon a subjective history, you cannot express an opinion within medical probability that it was [claimant's] work activity in 1982 and not off-the-job factors that were the contributing elements to [claimant's] current worsened condition."

The Referee found that claimant, "although not a perfect historian and despite withering cross-examination, was a credible and essentially reliable witness." He found Ms. Pedro, the collections manager for the doctor's clinic, neither reliable or credible. He found Ms. Erb, the trust administrator's representative, credible and partially reliable and considered Ms. Dwinell, the claims examiner, totally credible and reliable.

The Referee concluded Consolidated Freightways was responsible for both the 1979 claim and the 1982 aggravation. Consolidated Freightways was also assessed a penalty and accompanying attorney fees for a late and unreasonable denial.

We disagree with the Referee's conclusion. Therefore, we reverse.

When credibility is an issue, great weight is given to the Referee's findings. Bush v. SAIF, 68 Or App 230, 233 (1984). Although we generally defer to the Referee's credibility finding, here we find claimant's version of the facts so inconsistent and contradictory, that we are not able to rationalize them as merely the statements of an imperfect historian.

Since we find claimant's statements unpersuasive, it follows that claimant has failed to prove a compensable right shoulder claim in either 1979 or 1982.

Claimant's testimony that he sought medical treatment for his

right shoulder shortly after the alleged April 2, 1979 incident was not supported by Dr. Reichle's chart notes. Moreover, when claimant was examined on July 20, 1979 for his right shoulder, he did not relate his symptoms to his work and gave a history of pain over the preceding 6 to 12 months. Interestingly, Dr. Reichle had examined claimant twice between the alleged April incident and the July examination. Claimant's alleged right shoulder problem was not mentioned in either chart note concerning the interim examinations.

In addition, claimant is by no means a novice to claims processing. However, he did not direct the medical bills to his employer's workers' compensation carrier, but instead had his private carrier billed. We find it hard to believe that an experienced claimant would not have referred the bill to his workers' compensation carrier if he had the least bit of a suspicion that his condition might have been work-related.

Finally, we are unable to find substantiation for the Referee's finding that Ms. Pedro, the medical clinic's collection manager, was neither reliable nor credible in any respect. Claimant admitted that he probably had billed his private insurer. Thus, Ms. Pedro's testimony was corroborated on at least that particular point.

Since we affirm Consolidated Freightways' denial, it follows that the denial was not unreasonable. Therefore, no penalty or accompanying attorney's fee was warranted.

Neither are we persuaded that claimant filed his 1979 claim with his employer in July 1979. Thus, we find that a penalty for unreasonable delay was not justified. Although claimant's "worker's receipt" of the claim was apparently signed by his supervisor, it was incomplete. According to Ms. Dwinell's totally credible and reliable testimony, such an incomplete claim would not be accepted. Furthermore, no claim had ever been lost in the system, as this claim purportedly was, in the examiner's five years of experience. Finally, claimant admitted that occasionally claim forms were taken home, but not returned.

Since Dr. Harvey's opinion that claimant's 1982 work activities independently contributed to an aggravated and worsened right shoulder condition rested solely upon claimant's subjective history, it follows that claimant has likewise failed to prove a compensable 1982 right shoulder claim. Medical evidence on causation is only as competent as the medical history upon which it is based. As we have noted above, claimant's testimony, and thereby his medical history, is neither credible nor reliable. Accordingly, Dr. Harvey's opinion concerning causation is entitled to little weight.

Furthermore, claimant's right shoulder condition had been symptomatic prior to his 1982 claim. Thus, in order to prove a compensable occupational disease claim, he must establish that his work activity caused a worsening of the underlying condition. Weller v. Union Carbide, 288 Or 27 (1979). In addition, he must prove that his work activity was the major contributing cause of the worsening. SAIF v. Gygi, 55 Or App 570 (1982). We are not persuaded that claimant has established either prong of his requisite burden of proof.

ORDER

The Referee's order dated March 31, 1983 is reversed in part and affirmed in part. That portion which set aside Consolidated Freightways' denials and assessed it a penalty and accompanying attorney fees for a late and unreasonable denial is reversed. Consolidated Freightways' denials of July 12, 1982 are reinstated and affirmed. That portion of the order which affirmed Freightliner's denial of June 11, 1982 is affirmed.

MICHAEL T. SIMKOVIC (Deceased), Beneficiaries of
Galton, et al., Attorneys
Meyers & Terrall, Attorneys

WCB 83-06258
July 25, 1984
Order of Dismissal

The insurer requests review of of Referee Braverman's order which directed that it continue paying workers' compensation benefits pursuant to the terms of a May 18, 1983 order entered by the Evaluation Division of the Workers' Compensation Department, which ordered payment of death benefits provided by ORS 656.204, as well as any accrued compensation for temporary disability benefits not paid to the decedent while living. The Referee also ordered the insurer to pay a penalty equal to 25% of all benefits due and a $1,000 attorney's fee for the insurer's "unreasonable conduct in this claim." The only issue raised by the insurer's request for review is the propriety of the Referee's award of a $1,000 attorney's fee, which the insurer correctly notes was imposed as a penalty.

Claimant sustained a compensable low back injury on July 6, 1982 while working as a long haul truck driver. He was treated conservatively at first. A herniated disc subsequently was diagnosed, and claimant was hospitalized for surgery in February of 1983. While recovering from surgery, claimant had a cardiopulmonary arrest. On March 3, 1983 claimant was pronounced brain dead.

On May 18, 1983 the Evaluation Division issued a document entitled "Determination Order," stating:

> "The Department is advised and finds that Michael T. Simkovic was injured and is entitled to workers' compensation benefits, that there was time lost from work because of this injury, and that death resulted from such injury. The Department finds the decedent entitled to compensation for temporary partial disability inclusively from July 16, 1982 through January 17, 1983; and for temporary total disability inclusively from January 18, 1983 through March 3, 1983.
>
> "The Department orders the named insurance company to pay to the person or persons entitled to receive death benefits as provided in ORS 656.204, any accrued compensation for temporary disability not paid to the decedent while living.

> "The Department further orders the named insurance company to pay to the worker's beneficiaries an award of compensation for fatal injury. The named insurance company is ordered to notify the worker's beneficiaries of the size of the periodic payments to be made as a result of this award."

By letter dated May 25, 1983 the insurer informed decedent's widow of the benefits payable "as a result of that Determination Order."

By letter dated June 30, 1983 the insurer denied payment of further benefits, stating: "We have further reviewed this file and it is our opinion that there is insufficient medical evidence available to substantiate the award of benefits for a fatal injury as granted per the Determination Order of May 18, 1983."

On July 6, 1983 the Board received a hearing request filed by counsel for the decedent's beneficiaries contesting the insurer's June 30, 1983 denial. In addition, a Motion for an Order to Show Cause was filed on the basis of former OAR 436-83-290 (see OAR 438-06-075, effective May 1, 1984). On July 4, 1983 the Presiding Referee entered an order requiring the insurer to appear and show cause for its alleged failure to pay compensation. The insurer subsequently filed responses to the Motion for an Order to Show Cause and to claimants' hearing request. Pursuant to the Presiding Referee's show cause order, a hearing convened before Referee Braverman on July 27, 1983, which led to the order presently before us.

Claimant has moved to dismiss the insurer's request for review. Claimant contends that the Referee's order is in the nature of an interim order and, therefore, not presently subject to review pursuant to ORS 656.295. We previously denied claimant's motion for dismissal and granted leave to renew the motion in claimant's respondent's brief. 35 Van Natta 1374 (1983).

Both parties rely upon our order in Harris E. Jackson, 35 Van Natta 1674 (1983), in support of their respective positions concerning the finality of this Referee's order. In Jackson we determined: "Considering this [Referee's] order in the context of the proceeding that led up to it, we conclude that it is closer to the interim end of the interim-final continuum." 35 Van Natta at 1677. We believe that the same holds true with respect to the Referee's order presently before us.

One of the factors we have taken into consideration in making this determination is the issue raised by the employer's request for review. The thrust of the employer's argument is that the fee is excessive, taking into consideration the efforts expended by counsel and the results obtained in claimant's behalf, see generally OAR 438-47-010(2); and that the attorney's fee which the Referee obviously awarded under authority of ORS 656.382(1), should reflect only efforts expended and results obtained without consideration of the nature of the employer/insurer's allegedly unreasonable conduct. But see William H. McCall, 35 Van Natta 1200, 1201 (1983); Zelda M. Bahler, 33 Van Natta 478, 481 (1981), rev'd on other grounds 60 Or App 90 (1982).

In any event, it would seem to follow, by virtue of our determination that this Referee's order is an interim order, that the insurer is not presently required to pay the $1,000 attorney's fee, although the insurer is required to process the claim and pay compensation in accordance with the remaining terms of the Referee's order. Cf. Reed v. Del Chemical, 26 Or App 733, 741 (1976). Because we conclude that the Referee's order is an interim order, it necessarily follows that the Board lacks jurisdiction of this proceeding at the present time.

ORDER

The insurer's request for review of the Referee's July 27, 1983 order is dismissed as premature. Claimant's attorney is awarded $350 for services before the Board.

BETTY L. WILLIAMS, Claimant
Peter Hansen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 80-10620
July 25, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of those portions of Referee Menashe's order which set aside its partial denial of claimant's memory disorder and dementia. The Referee also upheld two other partial denials; those rulings have not been raised as issues on review.

Claimant compensably injured her neck and shoulder in 1978. In August 1979 Dr. Misko recommended a cervical discectomy. He noted, however, that claimant had a right carotid bruit which should be looked into before the compensable cervical surgery was performed. That investigation led to the conclusion that claimant's preexisting carotid bruit required surgical correction independently of her compensable neck injury and before any other surgery was performed. Dr. Misko thus performed a carotid endarterectomy in September 1979. On October 23, 1979, Dr. Misko performed the compensable cervical discectomy.

Claimant and her family testified that she began to experience memory lapses beginning around the time of her carotid surgery in September 1979. A vocational consultant mentioned that he noticed memory problems in June 1981, but there was apparently no follow up. There is no other mention in the extensive medical records of any memory problems until June 1982 when claimant began seeing a second psychologist.

Dr. Brewster Smith performed a neurological examination on claimant on September 17, 1982. He opined that her memory problem might be the result of a cerebral vascular accident at the time of her earlier surgeries. He also said she might have an early presentation of Alzheimer's disease. In November 1982 Dr. Smith opined:

> "This patient has evidence of mild dementia manifested primarily by impairment of short term memory, tracking and mental control. The etiology of this dementia is uncertain. It has been postulated that she suffered a small cerebral infarction at the

> time of her carotid endarterectomy. This theoretically could have been possible in that cerebral infavct [sic] is a not uncommon occurrence after endarterectomy. There is no objective evidence documented during that hospitalization to support this diagnosis."

On April 4, 1983 Dr. Smith again commented that the etiology of claimant's memory problems was uncertain. He ruled out Alzheimer's disease at that time. He noted that the temporal connection between the endarterectomy and the onset of claimant's memory problems "point to a possible causal connection."

Dr. Rosenbaum evaluated claimant on May 3, 1983. He stated, in essence, that there is really no way to determine whether the memory problem was caused by the endarterectomy. He noted that it could be caused by Alzheimer's disease or dementia of other uncertain origin.

The Referee concluded that the medical evidence supports the conclusion that claimant's memory disorder was caused by the endarterectomy. We disagree.

We note that it is uncertain that any sequelae from the endarterectomy would be compensable because there is a question whether the endarterectomy itself was a compensable sequela of the accepted injury. However, we need not reach that issue because we find that claimant has failed to prove by a preponderance of the evidence that her memory problem was caused by the endarterectomy.

The credible lay testimony establishes that claimant's memory loss and dementia began about the time of her endarterectomy. However, we think that whether the latter caused the former is in the outer range of medical complexity, an area in which just evidence of temporal connection is generally insufficient to prove causation. Edwards v. SAIF, 30 Or App 21 (1977). While Dr. Smith opined that the endarterectomy was a possible cause of claimant's memory loss, he was unwilling to opine that it was the probable cause of claimant's memory loss. His ultimate opinion seems to be that the etiology of the memory loss is uncertain. Dr. Rosenbaum is of the same opinion. On the basis of this evidence we are unable to say that claimant has proven that it is more probable than not that the endarterectomy caused her memory problems.

ORDER

The Referee's order dated December 12, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order which set aside the insurer's partial denial of claimant's memory problems and dementia are reversed. The balance of the Referee's order is affirmed.

CONRAD M. YUCKERT, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-06221
July 25, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Podnar's order which upheld the self-insured employer's denials of claimant's current condition and further treatment. Claimant contends that the denials are barred under Bauman v. SAIF, 295 Or 788 (1983).

The Board affirms the order of the Referee. The denials did not deny compensability of the claim ab initio, but rather, denied claimant's current condition and further treatment. We do not believe the intent of Bauman is to bar such partial denials. Waunita M. Walker, 36 Van Natta 44 (1984); Clyde Wyant, 36 Van Natta 1067 (July 5, 1984).

ORDER

The Referee's order dated September 16, 1983 is affirmed.

ROBERT F. ANDERSON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10914 & 83-03009
July 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of those portions of Referee Daron's order which upheld the SAIF Corporation's partial denials of claimant's right carpal tunnel syndrome and alleged bilateral thoracic outlet syndrome.

Claimant has an accepted claim for a left hand injury sustained in February 1982. The Referee found that claimant's left carpal tunnel syndrome was related to that hand injury, and no issue is raised on review concerning that finding.

As for the remaining claims for right carpal tunnel syndrome and bilateral thoracic outlet syndrome, we find considerable confusion in the record. The threshold ambiguity is whether claimant is asserting these claims on an occupational disease theory or whether claimant contends that these conditions are secondary to his February 1982 hand injury. In this regard, we note that, although claimant testified he had pain in both wrists, i.e., carpal tunnel symptoms, and pain in both shoulders, i.e., thoracic outlet symptoms, before the February 1982 accident, most of the medical reports record a history of wrist and shoulder pain only after that accident. Dr. Clibborn's June 22, 1982 report is typical: "[Claimant] stated that his pain came on gradually following his injury at work."

This ambiguity carries over into the expressions of medical opinion, which are quite diverse. Dr. Ellison states in a June 8, 1982 chart note that claimant has bilateral thoracic outlet symdrome but "whether or not it is employment related is problematical." Dr. Clibborn's June 22, 1982 report, which is also quoted above, did not find thoracic outlet symdrome but

rather a cervical strain; Dr. Clibborn theorized that, when claimant lacerated his left hand in February 1982, "he jerked violently backwards creating a whiplash type of injury to his neck and upper back." Dr. Ellison's July 26, 1982 chart note states: "I am not equipped to relate [claimant's] thoracic syndrome to industrial exposure, which [claimant] is pushing for." In a February 9, 1983 report, Dr. Gerster opines that "the continuous pushing and pulling motions" claimant did working in the mill "definitely aggravated the thoracic outlet compression." Dr. Korn's May 5, 1983 report seems to summarize the medical uncertainties:

> "As the accident on the 26th of February 1982 involved the dorsum of his hand quite distally and that objective evidence of his carpal tunnel syndrome indicated the right hand worse than the left, I believe it is unlikely that the accident contributed significantly to this problem. As mentioned before, it is conceivable that it is work-related to his previous activities prior to the accident. It is unfortunate that documentation of his problems prior to the injury is not possible, as this makes etiology of the problems more obscure."

On this record, we agree with the Referee's conclusion that claimant did not sustain his burden of proof.

ORDER

The Referee's order dated July 7, 1983 is affirmed.

DARLENE L. BIRTCH, Claimant
JOYCE L. DEPEW (Deceased)
Pozzi, et al., Claimant's Attorneys
Allen & Vick, Attorneys
SAIF Corp Legal, Defense Attorneys

WCB 83-01758
WCB 83-01928
July 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Thye's orders on these consolidated cases which set aside its denials of February 7, 1983 and February 9, 1983. Apparently the only issue for review is whether the claimant, Darlene Birtch, and the decedent, Joyce Depew, were subject workers on September 3, 1982.

Claimant, Darlene Birtch, was hired to be a shift manager by Robert Wert (aka Robert West) on August 2, 1982. Wert was the owner of a gambling establishment known as the Whiskey Hill Adult Recreation Center, located in a rural area of Clackamas County. Birtch's duties included dealing, making sure that there were always dealers available to deal blackjack and poker and other games, answering the door, handling the money and waiting on customers when necessary. Birtch's working shift was from 2:00 a.m. to 10:00 a.m., and she was paid $7.50 per hour. Birtch's wages were paid in cash out of the gambling receipts at the end of each shift.

Claimant Depew was also employed by Wert in the same establishment. Depew was hired to be a dealer, and also worked from 2:00 a.m. to 10:00 a.m. Depew was paid $5.00 per hour which, similar to Birtch, was paid out of gambling receipts at the end of each shift.

Daniel Lee Holterman (aka "Dan the Jeweler") was a regular customer at the Whiskey Hill Adult Recreation Center, and was known by Birtch. A short time after 2:00 a.m. on September 3, 1982, Holterman entered the premises, purchased some gambling chips and began playing blackjack with Depew. After about an hour of gambling and losing, Holterman left the building to go to his car, obstensibly for more money. Holterman returned, however, brandishing a shotgun and demanded that Birtch turn over all of the gambling receipts to him. Birtch complied and Holterman ordered both her and Depew to lay face down on the floor. Holterman then stood between Birtch and Depew and shot both of them in the back. Birtch was seriously wounded and Depew was killed. Holterman was eventually tried, convicted and sentenced to life imprisonment. Robert Wert apparently disappeared shortly after the shooting.

Claims were filed on behalf of Depew for her minor son, and by Birtch. The claims were apparently sent to the Compliance Division of Workers' Compensation Department. The Compliance Division found no records indicating that Robert Wert and/or the Whiskey Hill Adult Recreation Center was a complying employer on September 3, 1982, or for that matter, for at least two years prior to the shooting incident. However, an order declaring Robert Wert to be a noncomplying employer was not issued. See ORS 656.052(2). Instead, on January 24, 1983 the Compliance Division referred the claims to SAIF for processing. See ORS 656.054(1). The Compliance Division advised SAIF to deny both claims because, "[t]he contract(s) of employment call for the performance of acts that are themselves violation of penal laws."

On February 7 and February 9, 1983 SAIF denied both claims for the reasons recited above.

A consolidated hearing on both claims was held on June 27, 1983. The Referee concluded that Wert was a subject employer and that Birtch and Depew were subject employes on September 3, 1982. The Referee also concluded that both claimants were engaged in activities that were a violation of the Oregon gambling laws. ORS 267.117(2) and 167.121. The Referee additionally stated:

> "The crux of the compensability of these claims is SAIF's contention that, due to the illegality of the acts performed by claimants pursuant to their contract of employment, public policy prevents them from qualifying for benefits under the workers' compensation system."

The Referee stated that since ORS 656.027 stated that all workers are subject to ORS 656.001 to 656.794 except those specifically enumerated, and since there is no specific exemption for workers employed to perform illegal activities, that the maxim, inclusio unius est exclusio alterius (the inclusion of one is the exclusion of another) resulted in the conclusion that Birtch and Depew were

subject workers at the time of the shooting incident, and that the claims were, therefore, compensable.

As SAIF notes, these consolidated cases present an issue of first impression in Oregon. SAIF argues that there is a strong public policy against aiding those who commit criminal wrongs and that it could not have been the intent of legislature to compensate those who are injured while in the process of violating the state's criminal code. SAIF also argues that there was no contract of employment in existence between claimants and Wert because the contract called for the performance of illegal acts and was thus void ab initio.

Claimants' arguments basically agree with the analysis of the Referee.

We begin by agreeing with the Referee's conclusion that the claimants were engaged in activities which constituted a violation of the Oregon criminal code. ORS 167.121(12) provides that a "social game" means:

> "(b) if authorized pursuant to ORS 167.121, a game, other than a lottery, between players in a private business, private club or place of public accomodation where no house player, house bank or house odds exist and there is no house income from the operation of the social game."

ORS 167.122 provides that:

> "(1) A person commits the crime of promoting gambling in the second degree if he knowingly promotes or profits from unlawful gambling."

ORS 167.121 provides:

> "Counties and cities may, by ordinance, authorize the playing or conducting of a social game in a private business, private club or in a place of public accommodation. Such ordinances may provide for regulation or licensing of the social games authorized."

Michael Machado, a detective with the Clackamas County Sheriff's Office, testified at the hearing. Machado had been involved in an undercover investigation of the Whiskey Hill Center prior to the September 3, 1982 shooting incident. Machado testified that at the time of the shooting incident, Clackamas County did have an ordinance that permitted social gambling, but that anything involving a "house take" or "house odds" was (as provided in the statute) prohibited.

There is little dispute in this case that the "house" received income from the operation of various games on the premises. In fact, the house took all of the receipts other than amounts used to pay its dealers. Based on officer Machado's testimony, there is also little doubt that claimant Birtch (and we infer from the record, Depew also) knowingly promoted and/or profited from the gambling operation.

Having determined that Birtch and Depew were employed to engage in illegal activities, the next question is, whether under the circumstances of this case, compensation is precluded for that reason. We find that compensation is precluded.

Strictly speaking, the Referee was correct in concluding that pursuant to ORS 656.023 Wert was a subject employer and that Birtch and Depew, pursuant to ORS 656.027, were subject employes, ORS 656.023 provides that, "Every employer employing one or more subject workers in the state is subject to ORS 656.001 to ORS 656.794." As previously noted, ORS 656.027 provides that, "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:" (Emphasis added.) None of the subsections of ORS 656.027 state that workers employed for the performance of illegal activities are exempt. Thus, strictly construing the statutes leads to the conclusion that Wert was a subject employer and that Birtch and Depew were subject employes.

We do not believe, however, that a strict construction of the statutes necessarily resolves this problem. For example, ORS 656.005(28) defines a "worker" as, "[a]ny person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer . . . ." (Emphasis added.) Thus, utilizing the Referee's reasoning and applying a different maxim of statutory construction, as previously expressed, that the expression of one is the exclusion of another, would lead to the conclusion that since the legislature specifically included unlawfully employed minors in the definition of "workers," that other unlawful employments are excluded. Therefore, since workers employed to engage in illegal activities are not included in the statutory definition of "workers," they could not be subject workers pursuant to ORS 656.027.

Thus, a strict construction of the statutes could as easily lead to the conclusion that Birtch and Depew are not subject workers. As we indicated above, however, we do not believe that attempting to strictly construe the statutes is necessarily the best method for answering the question presented by this case. Our above analysis, however, is an additional basis for our conclusion.

In his treatise on workers' compensation law, Professor Larson discusses the question of illegal employment:

> "Although it could be argued technically that a requirement of a 'contract of hire' can be satisfied only by showing a legal contract, the cases have generally drawn a distinction between contracts that are illegal in the sense that the making of the contract itself violates some prohibition, and contracts that call for the performance of acts that are themselves violations of penal laws. The former will ordinarily support an award of compensation; the latter will not." 1c Larson's Workmen's Compensation Law, §47.51, page 8-291, 292, (8th ed. 1982).

We believe Professor Larson's distinction is particularly useful in solving compensability questions involving employment for the performance of illegal activities. It makes little sense to punish an employe engaged in otherwise legal employment activities simply because the contract of hire itself is a violation of law. In such a case, the violation has nothing to do with the actual injury. This is not true, however, when the activity to be performed is itself a violation.

Larson gives examples:

> "[C]ompensation was awarded to a nightclub hostess in spite of the existence of a statute prohibiting the very contract under which she was hired, since the duties she was required to perform-the mere encouraging of patrons to drink, on a commission-did not themselves constitute violations of [the] penal statute." Larson supra, §47.51 at 8-292.

Larson additionally notes a Tennessee case, Bowers v. General Guar. Ins. Co., 430 S. W. 2d 871 (Tenn. 1968) involving a claimant who was assaulted while making an illegal liquor sale, in a building separate from the building operated by the employer for legal sales of beer. The Tennessee statute defining "employee" was virtually identical to ORS 656.005(28) which defines "worker." The Tennessee court concluded that compensation would be allowed even if the contract of employment were illegal so long as the duties required by the contract were legal, but that compensation would be denied if the contract called for the performance of acts which were themselves illegal. 420 S.W. 2d at 872.

Thus, utilizing the illegality of contract versus the illegality of performance distinction, it is irrelevant in the current case whether the contract of hire between Wert, Birtch and Depew was itself prohibited, because the contract called for the performance of acts which were themselves violations of Oregon's penal statutes. Thus, compensation should be denied.

Even without the illegality of contract versus illegality of performance distinction, we would be inclined to deny compensation in the current case. We believe that the concept of "legality" underlies the entire concept of the workers' compensation statutes. It would be difficult to conclude that the legislature, assuming that it considered the matter, would have intended a "mafia hitman" who was injured by the police while on an assignment, to be able to file a workers' compensation claim. Yet, this would be the not-so-impossible-to-imagine-extreme, if we were to adopt the Referee's reasoning in this case.

It is also important in the context of this case to distinguish contracts of hire which call for the performance of illegal acts, from the commission of an act in the course of otherwise legal employment activity, which although illegal, constitutes no more than negligence. For example, the worker in Boyd v. Francis Ford, Inc., 12 Or App 26 (1973), was a car salesman who was killed while driving with a .37 blood alcohol

content: a violation of Oregon law. The worker, however, had been attempting to sell a car prior to his death. The fact that the worker had been drinking heavily before the accident was found to constitute nothing more than negligence, which is insufficient to preclude coverage. 12 Or App at 31. Thus, although a given act on the part of a worker may itself be illegal, it may be found to constitute mere negligence in the context of his or her otherwise legitimate employment activities. As indicated by the court in Boyd, this would normally not preclude coverage.

Claimants argue that a finding of noncompensability in this case would serve to encourage other employers involved in illegal activities to avoid the purchase of workers' compensation coverage since they would not be liable for any injuries related to such work. In reality, we doubt that a finding of compensability would encourage such employers to purchase workers' compensation insurance. Purchasing coverage would increase such an employer's risk of being prosecuted for his illegal activities, and the risk of such prosecution is substantially greater than the penalties such employers face for noncompliance with the workers' compensation laws.

In his amended order, the Referee concluded that although he found both claims compensable, he had no authority to order SAIF to pay benefits as a noncomplying employer order had never been issued by the Workers' Compensation Department. Since we have concluded that the claims are not compensable, it is unnecessary for us to address this conclusion.

ORDER

The Referee's orders dated July 27, 1983 and September 19, 1983 are reversed. The SAIF Corporation's denials dated February 7, 1983 and February 9, 1983 are reinstated and affirmed.

KENNETH L. ELLIOTT, Claimant
Emmons, et al., Claimant's Attorneys
Luvaas, et al., Defense Attorneys

WCB 81-08152
July 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The insurer requests review of Referee Baker's order which directed that claimant's 1979 back injury claim be reopened effective October 30, 1982, although it is not clear that claimant ever made an aggravation claim and we find no aggravation denial in the record. However, no procedural issue is raised; the insurer argues only that, substantively, claimant has not established entitlement to claim reopening. We agree with the insurer's contention and thus reverse.

Claimant has suffered two industrial injuries to his low back. The first injury occurred in November 1974, and resulted in foraminotomies of L5 and S1 nerve roots and partial laminectomies of L4-5 and L5-S1 on the left. Claimant received 30% permanent disability as a result of this injury.

Claimant's second low back injury, the injury here in issue, occurred in March 1979. Following a variety of conservative

treatments and several hospitalizations without additional surgery, this claim was ultimately closed by Determination Order dated June 28, 1982. Claimant was awarded an additional 15% permanent disability.

Dr. Boughn has been treating claimant since 1976. In May 1982 Dr. Boughn found claimant medically stationary. The June 1982 Determination Order was issued based on this opinion. While there was some confusion at the start of the hearing about what the issues were, we do not understand claimant to contend that this Determination Order prematurely closed his claim.

On October 2, 1982 claimant was again hospitalized. His condition was diagnosed as an acute exacerbation of chronic lumbosacral strain and lower back disease. Claimant received traction, analgesia and muscle relaxant therapy. He remained in the hospital receiving this conservative treatment until October 30, 1982. The insurer paid additional time loss compensation for this period.

By letter dated October 28, 1982, Dr. Boughn reported that claimant's hospitalization represented the "normal waxing and [waning] of symptoms in a person with this sort of significant disability." Dr. Boughn announced that he was initiating trigger point injection therapy, but opined that the claim need not be reopened.

After about nine months of Dr. Boughn's injection therapy, which apparently produced limited relief, in June 1983, at claimant's request, Dr. Boughn referred claimant to Dr. Arden, a chiropractor. The only report from Dr. Arden in this record is dated October 5, 1983. Dr. Arden reports that his treatment "has consisted of mild manipulation, traction, ultra sound, hot pacs, and massage, plus various orthopedic supports." Claimant testified that he saw Dr. Arden twice a week for the first three weeks of treatment, but since then had seen him on an average of once a week. Claimant stated that the treatments kept him going and were relaxing.

In his one report Dr. Arden diagnosed a "severe bi-lateral nerve root traction and foraminal compression of segments L5-S1 and L3-L4, with a slipped disc at L5-S1, and left leg sciatica," and opined "this is a direct re-aggravation related to a previous injury on 3/1/79." We are not sure what Dr. Arden means by "nerve root traction" or "direct re-aggravation," and Dr. Arden's report does not offer any explanation. We also note that, despite the extensive other treatment claimant received, there is no indication that the existence of a "slipped disc" was ever verified by x-ray, myelogram or otherwise.

Dr. Boughn treated claimant on at least two occasions after claimant began seeing Dr. Arden. Dr. Boughn's chart notes illustrate the fluctuations of claimant's symptoms. On July 21, 1983 Dr. Boughn reported that claimant was not responding to chiropractic treatment. On July 29 claimant reported to Dr. Boughn that he did very well the prior week, but desired another trigger point injection because he would be traveling that week. Dr. Boughn administered another injection.

The Referee ordered the claim reopened, reasoning that claimant remained under active treatment which the treating physician, Dr. Arden, characterized as curative for an aggravation.

We disagree. Although, as previously noted, some procedural ambiguity is created in this record by the apparent absence of a specific aggravation claim or denial, claimant must nevertheless establish a worsening of his condition after the last award of compensation (the June 1982 Determination Order) to warrant claim reopening. We conclude that claimant has not so established. It is not even clear that Dr. Arden's cryptic report opines that claimant's condition worsened after June 1982; if it does so opine, we find it unpersuasive. Dr. Boughn, claimant's treating doctor since 1976, did not feel that claimant's condition warranted claim reopening at any time after June 1982. Dr. Boughn continued to treat claimant during the time claimant was receiving Dr. Arden's treatments. At no time during this period did Dr. Boughn indicate claimant's condition had worsened.

Dr. Boughn's chart notes after June 1982 document the fluctuating nature of claimant's symptoms as do the chart notes from before June 1982. We do not find it noteworthy that a claimant with 45% permanent low back disability experiences flareups of symptoms. According to claimant's history, periods of more acute and less acute symptoms have arisen in the past and, it is safe to assume, will continue to occur periodically. Such a "waxing and waning" is to be expected and does not require the reopening of a claim.

The other issue is the extent of claimant's permanent disability. The parties have asked us to take official notice that, after the Referee ordered reopening, this claim has been reclosed by a March 12, 1984 Determination Order and that claimant has requested a hearing on that Determination Order. We can take such notice and shall do so here. Dennis Fraser, 35 Van Natta 271, 274 (1983).

The hearing on the March 1984 Determination Order will pertain to the same issue presently before us. It is likely that more recent reports and opinions concerning the extent of claimant's permanent disability will be presented at the time of that hearing. Consequently, we deem it appropriate to remand the issue of the extent of claimant's disability rather than attempting to decide that issue on the present record. On remand, the extent of disability issue in this case shall be consolidated with WCB Case No. 84-02900, which involves claimant's request for hearing on the March 1984 Determination Order.

ORDER

The Referee's order dated November 18, 1983 is reversed, and this case is remanded to the Hearings Division for further proceedings consistent with this order.

VICKI L. GIBBS, Claimant
Gary Jensen, Claimant's Attorney
Edward Olson, Defense Attorney

WCB 83-09556
July 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of that portion of Referee Seifert's order which concluded that claimant was only entitled to interim compensation from August 18 to 29, 1983. The Referee also awarded a penalty and associated attorney fee which the insurer does not challenge.

Claimant sustained a left hand injury at work on August 18, 1983. By August 29 claimant's treating physician was of the opinion that: (1) the at-work injury caused only a contusion and some inflammation; (2) claimant also probably had a ganglionic cyst that was not caused by the work injury; and (3) the contusion/inflammation had resolved and, as to those conditions, claimant was able to return to regular work.

Matters are complicated somewhat by the fact that, as of the time of the expedited hearing in this case, claimant's claim was still in deferred status, i.e., the insurer had neither accepted nor denied the claim. We are advised that the insurer has since accepted the contusion/inflammation condition and partially denied the ganglion condition, and that claimant has requested a hearing on the partial denial.

Claimant argues in this case that she should receive time loss beyond August 29 because she was unable to work due to her ganglion condition. Claimant is probably correct if her ganglion condition is found compensable in the other pending case. However, based on the information that was available at the time of the hearing in this case, we agree with the Referee's conclusion that the insurer was not obligated to pay interim compensation beyond the date claimant's treating doctor gave her a full release to return to work. See Anna M. Scheidemantel, 35 Van Natta 740 (1983), rev'd in part, Scheidemantel v. SAIF, 68 Or App 822 (1984).

ORDER

The Referee's order dated December 2, 1983 is affirmed.

THOMAS C. MAY, Claimant
Cash Perrine, Claimant's Attorney
Horne & Tenenbaum, Defense Attorneys

WCB 82-11838
July 30, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review, and claimant cross-requests review, of Referee Daron's orders which: (1) affirmed a Determination Order entered pursuant to ORS 656.325(3), which continued claimant's status as permanently and totally disabled; and (2) awarded claimant's attorney a $400 attorney's fee for services rendered at hearing. Insurer contends that claimant is not permanently and totally disabled and, therefore, the Referee's determination is in error. Claimant contends that the Referee's award of attorney fees is inadequate in view of the efforts expended and results obtained in claimant's behalf.

On the issue of claimant's permanent, total disability status, we affirm and adopt the Referee's order. We agree with the Referee's determination that the insurer has failed to satisfy its burden of proving that claimant presently is capable of regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a).

On the issue of attorney fees, we agree with claimant that the Referee's award is inadequate. Although the burden of proof in this case lies with the insurer, the record evidences counsel's entitlement to an additional fee at the hearing level. We modify the Referee's order accordingly.

ORDER

The Referee's orders dated September 30, 1983 and November 10, 1983 are modified in part. Claimant's attorney is awarded $600 in addition to the $400 awarded by the Referee, for a total fee of $1,000 for services rendered at hearing. The remaining portions of the Referee's orders are affirmed. Claimant's attorney is awarded $850 for services rendered on Board review, to be paid by the insurer.

ROBERT L. MONTGOMERY, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 83-04066
July 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Brown's order which set aside its denial of claimant's aggravation claim. The issue on review is SAIF's liability for claimant's worsened low back condition. SAIF contends that claimant sustained a new injury on March 12, 1983, while he was self-employed, which independently contributed to his low back condition, diagnosed as a recurrent lumbar disc. See Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).

The Referee concluded that claimant's worsened low back condition and consequential surgery were compensable under the standard of Grable v. Weyerhaeuser, 291 Or 387 (1981). Our review of the record establishes that claimant's aggravation claim is compensable under either the rule of Grable or the last injurious exposure rule. See Peterson v. Eugene F. Burrill Lumber, 294 Or 537 (1983). See also Dick A. Comstock, 36 Van Natta 1115 (July 25, 1984) (rule of Grable applicable in this factual situation).

ORDER

The Referee's order dated December 21, 1983 is affirmed. Claimant's attorney is awarded $650 for services on Board review.

ALANA C. MOORE, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-10689
July 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Nichols' order which upheld the SAIF Corporation's denial of reimbursement for an orthopedic mattress and box springs, but imposed a penalty and associated attorney's fee for SAIF's unreasonably delayed denial. Claimant contends that she is entitled to reimbursement for this furniture and that the $150 attorney's fee awarded by the Referee is inadequate. SAIF contends that the penalty/attorney's fee imposed by the Referee should be eliminated entirely because of claimant's failure to specify the untimeliness of the denial as an issue prior to or at the hearing.

With regard to the issue of the compensability of the orthopedic mattress, we affirm. Claimant concedes that OAR 436-69-201(7) is the administrative rule governing her entitlement to the mattress in question. See Lindsey v. SAIF, 60 Or App 361, 364 (1982); but see ORS 656.202(2). We agree with the Referee's conclusion that the evidence in support of claimant's position fails to satisfy the requirements of the applicable administrative rule, particularly that portion requiring a showing of "why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments."

We reverse the Referee's imposition of a penalty and attorney's fee. An amended hearing request filed by claimant in December of 1982 identifies the issues for hearing as claimant's entitlement to penalties and payment of attorney fees, and SAIF's failure to pay medical bills pursuant to ORS 656.245. When the hearing convened on October 26, 1983, the Referee stated the penalty issue as being, "penalties and attorney's fees for failure on the part of SAIF Corporation to reimburse the claimant for this expenditure," and claimant's attorney agreed. During his opening remarks, claimant's attorney stated in pertinent part:

> "The records will show that Dr. Boots prescribed on at least three occasions . . . an orthopedic mattress -- firm mattress for her to help her with her industrial injury for back pain and as early as October 1982 that was being recommended and the insurance company has, at first informally, and then just recently on September 8, 1983 formally denied payment of that. There is no -- our position is there is [no] basis for that refusal and [claimant] will testify briefly concerning her need for it whether she got it or not, and what it cost her, et cetera."

We understand the claimed basis for imposition of a penalty, as it was understood at the time of hearing, to have been penalties for SAIF's unreasonable refusal to pay compensation, i.e. SAIF's unreasonable denial of the orthopedic mattress in question. The possible issue of the timeliness of SAIF's denial was not adequately framed at the time of hearing, and claimant's hearing request generally designating penalties and attorney fees

as an issue certainly did not serve to put SAIF specifically on notice that this was an issue.

Our decision in Richard Pick, 34 Van Natta 957 (1982), is directly on point. We stated:

> "In Mavis v. SAIF, 45 Or App 1059 (1980), the court held that penalty issues have to be raised at the time of hearing. We understand this rule to require, for present purposes, that penalty issues be raised at an early point in the hearing process, i.e. in time for parties to present evidence on that issue. We believe, furthermore, that since the rationale of the Mavis rule is to permit introduction of relevant evidence there is some obligation to specifically define the claimed basis for imposition of a penalty so that it will be known what evidence is relevant. Stated differently, a general prayer for penalty such as contained in claimant's amended request for hearing is insufficient to put the employer/carrier on notice that it must offer evidence on any and all possible grounds for imposition of a penalty." 34 Van Natta at 959.

Although the penalty issue framed at hearing involved the unreasonableness of the denial, as opposed to its timeliness, the Referee imposed a penalty based upon her finding that claimant's "right to know" interest had been violated; in other words, that SAIF had unreasonably delayed denial of the claim. Based on our decision in Pick, we do not believe this was an appropriate basis for imposition of a penalty.

Assuming arguendo that the colloquy and opening remarks at the commencement of the hearing adequately raised unreasonable delay as a basis for imposition of a penalty, in view of the Referee's finding and our own concerning the compensability issue, there are no "amounts then due" which can form the basis for imposition of a penalty. For this reason, neither a penalty nor an attorney's fee can be imposed. EBI Companies v. Thomas, 66 Or App 105 (1983); Ray A. Whitman, 36 Van Natta 160 (1984); Darrell W. Carr, 36 Van Natta 16 (1984); Richard Davies, 35 Van Natta 25 (1983).

ORDER

The Referee's order dated November 23, 1983 is affirmed in part and reversed in part. That portion which imposed a penalty and attorney's fee for SAIF's unreasonably delayed denial is reversed. The remainder of the Referee's order is affirmed.

TOMMY G. PAYNE, Claimant
Harold Adams, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-05914
July 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Wilson's order which affirmed a September 14, 1983 Determination Order which awarded no compensation in addition to prior awards. Claimant previously has received awards for 10% (32°) unscheduled low back disability and 15% (22.5°) scheduled disability for partial loss of the left leg (thigh) in connection with this industrial injury. In addition claimant received 67.5° of scheduled disability for a 45% loss of his left leg as a result of an industrial injury prior to this December 1978 injury to the left leg. See ORS 656.222.

We agree with the Referee's determination that claimant is not entitled to an additional award of permanent disability, either scheduled or unscheduled, as a result of this industrial injury.

There is some question regarding the Referee's statement that "SAIF denied a request for a treadmill device and no appeal has been taken from that denial." In his request for review, which is claimant's only submission to the Board, claimant correctly identifies the fact that the origin of this proceeding was a request for hearing contesting SAIF's May 24, 1983 denial, issued in response to claimant's request that SAIF purchase a treadmill in connection with this claim. Claimant subsequently filed a supplemental hearing request in November of 1983, contesting the above-referenced Determination Order, which was entered upon completion of an authorized program of vocational rehabilitation. See ORS 656.268(5).

Although the Referee's statement that "no appeal [had] been taken" from SAIF's denial of the treadmill device is questionable, it is understandable that the Referee may have believed that claimant, by the time of hearing, was willing to concede that the purchase of this device was not a benefit payable in connection with this industrial injury claim. The colloquy between the Referee and counsel at the beginning of the hearing could certainly support this conclusion. Claimant's request for review, however, suggests that the Referee's failure to rule on the merits of SAIF's denial may have been the result of a misunderstanding; and, because we are not able to clearly conclude that claimant intended to waive this issue, we will proceed to consider claimant's entitlement to the treadmill device as an issue.

In a letter to SAIF dated February 23, 1983, claimant's then treating orthopaedic physician, Dr. Chester, reported:

> "[Claimant] asked if I thought a treadmill exercise apparatus would be good for him, and of course I concurred. A treadmill exercise apparatus would be good for anyone, but in his case it is one of the few pieces of equipment that might truly benefit him in terms of increased caloric expenditure, cardiovascular function and the like. He has difficulties

> participating in different exercise activities, for instance an exercycle is not practical due to the stiffness of his left knee wrought by those injuries mentioned above."

In a subsequent letter dated May 9, 1983, in response to an inquiry from SAIF concerning the medical necessity of the treadmill, Dr. Chester reported:

> "All I can say about the medical necessity of the treadmill is that it would be a nice thing for him to have, were it the kind that he could utilize if and when and how he wishes. It is not a medically necessary item and there is no way I can justify calling it a necessary item. It is more or less a luxury item. * * * If it requires me to say it is medically necessary, I am really not able to do that."

It does not appear that Dr. Chester ever issued a prescription for the treadmill device. Compare, Smith v. Chase Bag Co., 54 Or App 261 (1981) (cyclo massage chair recommended for claimant's ongoing palliative care not considered a "medical service" within the meaning of ORS 656.245), with Lindsey v. SAIF, 60 Or App 361, 363 (1982) ("Reimbursement for prescribed items such as [a] water bed is required by ORS 656.245(1) . . . ").

Assuming arguendo that Dr. Chester had "prescribed" the treadmill device, his statement that "it would be a nice thing" to have, but not a medical necessity, leads us to conclude that claimant has failed to establish his entitlement to this device in connection with his industrial injury claim. See OAR 436-69-201(7) (the pertinent administrative rule in effect at the time Dr. Chester "prescribed" the treadmill, Lindsey v. SAIF, supra, 60 Or App at 364); see also Barbara Dill, 32 Van Natta 248 (1981), Wayne M. Evenden, 32 Van Natta 54 (1981) (both decided on the basis of former OAR 436-69-335).

For the foregoing reasons, we find it appropriate to affirm SAIF's denial of the treadmill device in question.

ORDER

The Referee's order dated December 7, 1983 is modified to provide that the SAIF Corporation's denial for the purchase of a treadmill device, dated May 24, 1983, is affirmed. Except as so modified, the Referee's order is affirmed.

DONALD S. WILSON, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 83-03621
July 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of Referee Nichol's order which: (1) awarded him a total of 15% (48°) unscheduled permanent partial disability for his right shoulder injury, that being an increase of 10% (32°) from a December 8, 1982 Determination Order which had

awarded him 5% (16°); and (2) awarded him no scheduled permanent partial disability for his right forearm (wrist) injury, which was a decrease of 5% (7.5°) from the December 8, 1982 Determination Order's award.

We affirm and adopt that portion of the Referee's order which awarded claimant 15% unscheduled permanent disability. We reverse that portion of the Referee's order which did not award claimant scheduled permanent disability.

The SAIF Corporation correctly contends that claimant's right wrist was not injured at the time of his 1981 industrial shoulder injury. However, during rotator cuff surgery for claimant's shoulder injury, a bone graft was taken from his right wrist. Consequently, any wrist impairment that resulted from this surgery is itself compensable. Sparks v. SAIF, 60 Or App 397 (1982).

Claimant has received a prior award of 5% loss of the right wrist stemming from a 1974 injury. Although he was experiencing some stiffness in the right wrist before his 1981 shoulder injury, claimant testified that the wrist now "catches" or "snaps" and swells. Additionally, he has difficulty grasping objects and experiences numbness in two fingers.

Range of motion tests indicate that claimant has sustained a minimal permanent loss of dorsiflexion in the right wrist. However, no medical opinion indicates what portion of claimant's permanent impairment is attributable to his 1981 surgery.

We find that the evidence preponderates in favor of a finding that claimant has sustained minimal, increased right wrist impairment as a result of his compensable right shoulder injury and surgery. We conclude that the Determination Order's award of 5% loss of use of the right wrist sufficiently compensates claimant.

ORDER

The Referee's order dated November 18, 1983 is affirmed in part and reversed in part. That portion of the Referee's order which did not award claimant right forearm (wrist) disability is reversed and, in lieu thereof, that portion of the December 8, 1982 Determination Order which awarded claimant 5% (7.5°) scheduled right forearm (wrist) disability is reinstated and affirmed. The remainder of the Referee's order is affirmed.

CHARLES W. WRIGHT, Claimant
Steven Yates, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 83-03528
July 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Quillinan's order which upheld the insurer's denial of claimant's low back injury claim. Claimant contends that the Referee erred in ruling that he did not have a compensable claim because the turning motion, which precipitated his low back and leg pain, was an "ordinary action unrelated to claimant's work in the sense of flowing naturally from the employment." We agree with claimant and thus reverse.

On February 22, 1983 claimant was employed as a dishwasher. On that date, claimant was standing at a sink washing dishes in a bent over position when his employer entered the kitchen and spoke to him. Claimant turned and twisted to respond to the employer and immediately felt a sudden pain in his lower back and leg. Claimant saw his physician that day and was diagnosed as sustaining a work related lumbosacral muscle strain.

The only possibly complicating factor in this otherwise obviously compensable claim is: claimant had preexisting back pain since an automobile accident in September 1981. Claimant sustained neck, upper back and low back injuries at that time. The low back pain generally subsided, while the neck and upper back problems continued -- although they did not prevent claimant from working as a dishwasher. Claimant was also able to hunt elk, fish, camp, and drive his car. He had no problems sitting or standing.

Over about a five month period before the February 1983 injury, claimant reported mild or moderate lumbar pain at times to his chiropractor, Dr. Hebert. Because of claimant's continuing symptoms from the automobile accident, in January 1983 Dr. Hebert referred claimant to Dr. Myers for a neurological consultation. On the day of the work injury, February 14, Dr. Hebert reported an acute lumbosacral sprain for the first time. Also, claimant testified that he had not had leg symptoms before that day.

Claimant went to see Dr. Hebert the day of his injury. Dr. Hebert filed a claim on claimant's behalf the next day. In the box provided for a worker's statement of cause and nature of injury were the words: "washing dishes in kitchen -- turned toward boss & twisted lower back -- no equipment involved -- was not struck -- did not fall." Dr. Hebert diagnosed acute lumbosacral sprain with facetal syndrome and checked the box marked "yes" for whether the condition was work related.

Dr. Hebert again referred claimant to Dr. Myers and, on March 7, 1983, Dr. Myers found claimant to have complaints of acute low back and left leg pain. At the time of Dr. Myers' prior examination in January 1983, claimant had made no similar complaints. Dr. Myers reported:

> "[Claimant's] present difficulty developed acutely on the 22nd of February when, while working as a dishwasher, he turned to listen to his employer who was talking to him and in turning and twisting his low back had a sudden acute snap in the low back area which was associated by acute low back pain which radiated down the left leg. The pain had persisted fairly much unchanged to the present time and is described as radiating on the posterior aspect of the left thigh into the calf. He has not noticed any specific localized numbness in the foot. He has noted some tendency to stumble on the left foot. He has noted a notable accentuation of the pain in his low back if he would cough or sneeze, with radiation into the left leg."

Dr. Myers' neurological examination revealed the following:

> "In the lower extremities there appears to be a definite decrease in sensation over an L-5 and S-1 dermatomal distribution in the left lower extremity.
>
> "In gait, the patient walks in a slow manner favoring the left leg. He is unable to completely dorsiflex the left ankle when he attempts to heel walk at the present time although does not appear to have any weakness at this time."

Dr. Myers concluded that his findings suggested an acute L-5, S-1 disk herniation on the left and he admitted claimant to the hospital for further evaluation and treatment.

Testing revealed spinal canal stenosis at L-2 to L-3, slight bulging of the annulus at L3-4 on the left and nerve root defects at L3-4 and L4-5. Conservative care was recommended and claimant was placed on anti-inflammatory medication and physical therapy.

In response to questions from the insurer, Dr. Myers stated that claimant's low back and leg symptoms were consistent with the history he had received of claimant's at-work injury on February 22, 1983. Also in response to questions from the insurer, Dr. Hebert stated that claimant's condition was worse after the February 22, 1983 injury because his pain increased to the point that a herniated disc was suspected.

In summary, there are two physicians who examined or treated claimant before and after the February 22, 1983 incident; both obtained consistent histories from claimant as to the mechanism of the injury, a back twisting motion; and both physicians found a relationship between that injurious incident and claimant's worsened condition after that incident. There is no contrary medical opinion. The fact that the movement that claimant made at the time he sustained his injury was a common movement, in that he undoubtedly made the same type of turning movement both on and off the job, does not by itself disqualify a claimant from workers' compensation benefits. We are not aware of any requirement that a body movement, which results in an injury at work, be unusual or that it be a movement peculiar to the work activity. All that need be proven by claimant is that he was performing his work activity and that, as a result of that performance, he sustained injury. Claimant has so proven to our satisfaction.

ORDER

The Referee's order dated August 19, 1983 is reversed. The insurer's denial dated April 7, 1983 is set aside and claimant's claim is remanded to the insurer for acceptance and processing. Claimant's attorney is awarded $900 for services at hearing and $150 for services on Board review, to be paid by the insurer.

RICHARD A. WRIGHT, Claimant
David Hollander, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-11699
July 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Brown's order which found that the claim was prematurely closed by Determination Order dated December 20, 1982, found claimant medically stationary on November 16, 1982 and awarded claimant 32° for 10% unscheduled permanent disability. SAIF contends that the Determination Order should be reinstated. We agree and reverse the Referee.

Claimant compensably injured his low back and neck in February 1982. His treating doctor, Dr. Campagna, declared him medically stationary on August 13, 1982. Claimant was referred to the Callahan Center upon the recommendation of the Orthopaedic Consultants. On November 16, 1982 Dr. Storino reported that claimant was being discharged from the Callahan Center and that he was medically stationary. Dr. Storino noted that claimant complained of lightheadedness.

Claimant saw Dr. Taylor the following day, reporting the lightheaded symptoms. Although some precautionary instructions were given to claimant, no further treatment of those symptoms is found in the record. Claimant then was treated by Dr. Samuel, D.C. On December 23, 1982 Dr. Samuel reported that with seven treatments claimant's range of motion and muscle spasms had improved, which the doctor deemed a measurable improvement, and that claimant was not medically stationary. Later, Dr. Samuel reported that he had encouraged claimant to ride a horse to help his back.

Dr. Tennyson testified that horseback riding is contraindicated for a person with a bad back. He also testified that if the muscle spasms observed by Dr. Samuel were voluntarily induced by claimant, he would expect Dr. Samuel to so note in his examination. In addition, SAIF subpoenaed a witness who testified that during December 1982 she saw claimant riding and caring for his horse, which involved some strenuous activities.

Since the Referee doubted claimant's credibility, he only relied on Dr. Samuel's opinion to the extent that it was based on objective findings, as opposed to claimant's history. The Referee concluded that claimant did not voluntarily reduce his muscle spasms after November 16, 1982 and, therefore, claimant was not medically stationary on that date.

SAIF urges us to reject Dr. Samuel's muscle spasm findings in light of his questionable advice that claimant ride a horse to help his back. SAIF also observes that Dr. Storino did not note muscle spasms in his closing report. In addition, SAIF argues that the lightheadedness noted by Dr. Storino is a subjective symptom which should not negate the medically stationary finding, considering claimant's doubtful credibility. We agree with SAIF's contentions. Furthermore, we are persuaded by Dr. Storino's and Dr. Campagna's medically stationary findings and we find that claimant was medically stationary on November 16, 1982.

Having found that claimant was medically stationary as found

by the Determination Order, we reach the issue of extent of permanent disability, which claimant raised in the alternative. The Determination Order awarded claimant 32° for 10% unscheduled permanent disability. Considering claimant's impairment, social and vocational factors, and comparing this case with other similar cases, we find that claimant has been adequately compensated by the Determination Order award.

ORDER

The Referee's order dated August 10, 1983 is reversed. The Determination Order dated December 20, 1982 is reinstated and affirmed.

DONALD J. YOUNG, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06979
July 30, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee St. Martin's order which awarded claimant 40% (128°) unscheduled permanent disability in lieu of the Determination Order award of 10% (32°) disability. SAIF contends that the award is excessive. We agree with SAIF and reduce claimant's award.

Claimant's compensable injury has resulted in a chronic subluxating right shoulder. Claimant has received only conservative treatment, although Dr. Gritzka, Dr. Pasquesi and the Orthopaedic Consultants agree that claimant may eventually have to have surgery. Orthopaedic Consultants stated that relaxation of the capsule around the right shoulder joint makes claimant prone to reinjury, that claimant should not perform work that involves heavy overhead lifting and that his impairment is mild. Claimant's treating doctor, Dr. Gritzka, opined that the Orthopaedic Consultants minimized claimant's impairment, which is more appropriately in the mildly moderate to moderate range. However, Dr. Gritzka also stated that claimant has no particular limitations with regard to lifting. Dr. Pasquesi rated claimant's impairment as 23%, considering his loss of abduction, muscle weakness and chronic moderate pain.

Claimant has returned to work for the employer as a warehouseman. Although claimant is not able to perform the job he held when he was injured, he can still perform several jobs at the iron and steel plant that involve lifting, pushing and pulling steel. In fact, claimant was recently offered a foreman's job at a higher rate of pay, which he refused because it was on the graveyard shift. The employer's general superintendent testified that claimant is a good, hard worker. In addition, since his injury claimant has performed work at his home including shoveling, rototilling, laying sod, building a shed, putting on a roof, planting shrubs and moving and stacking wood.

We have considered the medical and lay evidence of claimant's impairment, claimant's current job capabilities, his off work activities, the opportunities for advancement in his job in spite of his impairment, his age of twenty-eight years, and his education including two years of college and an Associate Degree. ORS 656.214(5). Considering these factors and comparing this case with other similar cases, we find that an award of 25% (80°)

unscheduled permanent disability more appropriately compensates claimant.

ORDER

The Referee's order dated September 21, 1983 is modified. Claimant is awarded 25% (80°) unscheduled permanent disability in lieu of all prior awards. Claimant's attorney's fee shall be adjusted accordingly.

CHESTER L. BALDWIN, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-03253 & 83-03254
July 31, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The self-insured employer requests review of those portions of Referee Nichols' order which granted claimant 224° for 70% unscheduled disability for an injury on June 25, 1982 for which a Determination Order awarded no permanent disability. The Referee also affirmed an earlier Determination Order which granted claimant 16° for 5% unscheduled disability for an injury on August 28, 1981. The employer urges that the award be reduced. Claimant cross-requests review arguing that he is permanently and totally disabled. Extent of disability arising from the two compensable injuries is the issue on review.

In addition to the injuries already mentioned, claimant was compensably injured in November 1979 and received an award of 32° for 10% unscheduled disability as a result of that injury.

Claimant is a 61 year old furniture delivery driver with an eleventh grade education. He has repeatedly injured his low back. We find that his overall impairment is in the range of mildly moderate. Although claimant is precluded from his previous job, we find that he is not precluded from regularly performing work at a gainful and suitable occupation. Accordingly, we find that claimant is not entitled to an award for total disability.

After applying the administrative guidelines contained in OAR 436-65-600 et seq. and comparing this case with other similar cases, we conclude that claimant would be more properly compensated by an award of 144° for 45% unscheduled disability in lieu of the 224° for 70% unscheduled disability awarded by the Referee.

ORDER

The Referee's orders dated November 18, 1983 and November 23, 1983 are modified. Claimant is awarded 144° for 45% unscheduled disability for his injury of June 25, 1982 in lieu of the 224° for 70% unscheduled disability awarded by the Referee. Claimant's attorney's fee shall be adjusted accordingly. The balance of the Referee's order is affirmed.

SHARON M. GOW, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-07492
July 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Seymour's order which affirmed the SAIF Corporation's denial of her injury claim for an aneurysm. On review, claimant contends: (1) the Referee improperly considered a "scope of employment" defense not raised at hearing; (2) in the alternative, claimant was acting within the course and scope of her employment; and (3) claimant's work activity was the material contributing cause of her injury. If the Board finds the "scope of employment" defense was properly raised, claimant requests remand for the taking of further evidence on the issue. Finally, if the Board finds that claimant was acting within the course and scope of her employment when the injury occurred, she requests remand on the question of "medical causation."

The Board affirms the order of the Referee with the following comment.

Claimant is a 34 year old licensed tax preparer. In June 1982 she attended an out-of-town seminar conducted by the Oregon Society of Tax Consultants. For her attendance at the seminar claimant would receive credit hours necessary to maintain her license. Additionally, the credit hours of education brought claimant closer to qualifying for her Consultant's License examination.

There was no evidence presented that claimant's employer either required her to attend the seminar or paid for her tuition. Claimant's mother, one of her employers, also attended the seminar. The seminar was one of several methods available to obtain the requisite number of credit hours of schooling.

In connection with the seminar, a board meeting was scheduled. At the meeting, the Society's board of directors were scheduled to discuss whether to reprimand a member of the organization. The meeting was open to the general membership. Although claimant did not know the member in question, she took a position unpopular with the board and the approximately 30 people in the audience.

After espousing her controversial opinion, claimant experienced a warm feeling come over her skull from her neck and go over her eyes. She had difficulty seeing or hearing and soon had an excruciating headache. It was subsequently determined that claimant had suffered a subarachnoid hemorrhage resulting from a ruptured intercranial aneurysm. Soon after, surgery was performed.

SAIF denied claimant's injury claim. Without waiving other questions of compensability, SAIF stated that "medical information in the file indicates this condition is unrelated to your work activities." Claimant requested a hearing.

The Referee affirmed SAIF's denial. He reasoned that although it could be argued that the employer would benefit from

an employee's attendance at a seminar designed to increase knowledge and working skills, the same could not be said for the employee's attendance at a business meeting. The Referee concluded that nothing claimant could do or say at the business meeting would be sufficiently "work related" within the meaning of prevailing workers' compensation law.

Addressing claimant's initial argument on review, we find that the "scope of employment" defense was properly raised at hearing. The record indicates that compensability was raised as an issue in both SAIF's denial and at the commencement of the hearing. SAIF's denial specifically notes that it does not waive other questions of compensability, in addition to medical causation. Further, several questions bearing on the "scope of employment" defense were posed to claimant on cross examination. Claimant demonstrated no surprise at these questions and did not request a postponement.

We also deny claimant's request for remand for the taking of further evidence on the "scope of employment" issue. Our review of the record reveals that this case has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Finally, we agree that the claim is not compensable. We believe that claimant's attendance at the seminar in order to maintain her license as a tax preparer was insufficient to establish that her injury occurred during the course and scope of her employment.

The facts of this case are analogous to those presented in Haugen v. SAIF, 37 Or App 601 (1978). In Haugen, a police officer suffered a back injury while lifting weights at home during non-working hours. His job specification required that officers maintain a good physical condition and be subject to a biennial physical examination. However, his employer did not prescribe any particular exercise regime. Holding the claim noncompensable, the court stated that "the critical fact is that the risk of injury from claimant's physical conditioning program did not arise out of but rather was a condition to or qualification for the employment." Haugen, supra., at 605. The court went on to say that "the employee assumes the responsibility for, and correspondingly any attendant risk of, meeting the job qualifications." Haugen, supra., at 605.

Here, as in Haugen, claimant's employer did not prescribe the manner in which she fulfilled her education requirement in order to maintain her status as a state-licensed tax preparer. No evidence was presented to indicate claimant was required to attend the seminar or that her tuition was paid by her employer. The record suggests that claimant's decision to attend was her own. We are persuaded that the maintenance of her license did not arise out of her employment, but rather was a condition or qualification for the employment. Consequently, claimant assumes the responsibility for, and any attendant risk of, meeting her job qualifications. Accordingly, we find that claimant's injury while attending the seminar did not occur within the course and scope of her employment.

Since we have found that the injury did not occur within the

course and scope of claimant's employment, it follows that we need not decide her request to remand on the "medical causation" issue.

ORDER

The Referee's order dated January 10, 1984 is affirmed.

GEORGE W. HURST, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 82-05911
July 31, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The self-insured employer requests review of Referee Seymour's order which set aside its partial denial of claimant's medical treatment in the form of prolotherapy treatment.

Claimant sustained a compensable low back injury in 1976 for which he was subsequently awarded a total of 160° for 50% unscheduled permanent partial disability. His condition has been diagnosed as chronic lumbosacral strain, degenerative disc disease and obesity. Treatment for his compensable injury has been conservative.

Claimant began receiving prolotherapy treatments in January 1982 for his persistent low back pain from Dr. Ho, an osteopathic physician. The treatment was administered by Dr. Ho weekly at his office in Portland, requiring claimant, who lives in Myrtle Point, to drive a total of 536 miles round trip each week. Dr. Ho described the treatment as follows:

> "[Claimant] is receiving prolotherapy which consists of injections of a special solution which stimulates the body to form new fibrous tissue. This medication is injected into his injured ligaments which stimulate his body in effect to repair and strengthen injured ligaments thus stabilizing unstable joints which are otherwise painful with movement. This treatment is quite different from acupuncture."

The employer initially paid for this form of treatment. In March 1982 the employer had claimant examined by Orthopaedic Consultants, who opined:

> "From the best information that we can obtain, prolotherapy or the injection of a sclerosing agent about the back, is not a form of therapy prescribed by M.D. orthopedists, and apparently is not a generally accepted form of therapy and apparently rarely practiced by the osteopathic community. On this basis, we do not believe that [the employer] should be made responsible for this type of therapy. In addition, driving over 500 miles a week is only conducive to aggravation of his back complaints."

In June 1982 the employer received a communication from the Workers' Compensation Department, signed by the Director, which was sent to all insurers and self-insured employers, and which states in relevant part:

> "The Department's Committee of Medical Consultants discussed the use of prolotherapy and of implantation of certain electrical devices for the control of pain. Their opinions are as follows:
>
> > 'The committee discussed the procedures described as prolotherapy or sclerotherapy in the treatment of the painful or unstable back and concluded that this is not an acceptable form of therapy. A preliminary search of the literature provided no authoritative support for the procedure which seems to lack any physiological rationale. Only two physicians in Oregon are known to advocate the use of this procedure which has produced, in some cases, some very serious side effects. Until the proponents can produce credible scientific evidence in support of the procedure, it is recommended that the insurers not reimburse physicians for this procedure.'
>
> "These opinions of the Committee of Medical Consultants are forwarded in connection with Medical Rule 69-201(10) which reads as follows:
>
> > 'Insurers and claimants are not responsible for payment for treatment procedures rendered in connection with the compensable injury that are not approved and taught by accredited institutions of the licentiate's profession. If the insurer believes procedures to be inappropriate, of unproven value or experimental in nature, the issue may be referred to the Department for referral to a committee of consultants of the physician's peers.'"

By letter dated June 28, 1982, Dr. Ho reported a major improvement in claimant's condition, termed claimant's condition stationary and advised the employer that no further treatment was planned at that time.

By letter dated June 29, 1982, the employer partially denied Dr. Ho's prolotherapy treatment, advising claimant:

> "Relative to your treatment of prolotherapy by Dr. Ho, please be advised that the use of prolotherapy is not considered an acceptable form of treatment by the Workers Compensation Department Committee of Medical Consultants.
>
> "This opinion is now in connection with medical rule ORS [sic] 69-201(10)."

By letter dated October 5, 1982, Dr. Ho further described the prolotherapy treatments and provided a copy of his article on the subject published in the "Osteopathic Physician" magazine. Dr. Ho acknowledged his treatments were controversial:

> "Morris K. Crothers, M.D., Medical Director of the Workman's Compensation Department declared some months ago, after a meeting of his committee, that they found this treatment unscientific and that 'preliminary' search of the literature failed to reveal any scientific basis for the treatment or support for it. I have had extensive communication with Dr. Crothers and find that he failed to indicate that he was at all aware of those that I cited for him nor sent him. I have found the attitude of the Workman's Compensation Department prejudiced and ill-disposed to considering any new information along these lines."

Claimant testified that he felt the treatments helped him, they relieved his pain and that he had not noticed any side effects.

During the hearing, the Referee indicated that he intended to inquire about the composition of the Department's committee that had investigated the prolotherapy issue. Counsel for all parties indicated agreement with, or at least no objection to, this procedure. In his order, the Referee recited that his investigation revealed that all three committee members were medical doctors.

The Referee found that the disputed prolotherapy treatments were compensable. He reasoned that there was a general principle under ORS 656.245 that all treatment prescribed by a treating physician is compensable. He found fault with the Director's June 1982 communication to all insurers because the Department's committee had not been composed of Dr. Ho's peers. Finally, the Referee launched into a lengthy consideration of whether the Director's June 1982 communication should have been adopted pursuant to the rulemaking procedures of the Administrative Procedures Act, ORS ch 183, and concluded that it should have been adopted with that statutory formality.

We believe that the Referee's concerns about the meaning and proper application of the Administrative Procedures Act does little to advance analysis and resolution of the issue in this case. We agree that, in the cases that have involved medical

service questions under ORS 656.245, generally treatment recommended or rendered by a treating physician has been found to be compensable. The cases also make clear, however, that that is an outer limit of reasonableness. The central issue in this case is whether the prolotherapy treatments were necessarily and reasonably incurred as a means to treat claimant's pain stemming from a compensable injury.

The fact that a form of treatment is novel or unusual does not necessarily mean that it is unreasonable. For example, in Allen Davis, 33 Van Natta 564 (1981), we found that the claimant's palliative acupuncture treatments were reasonable and compensable. In Davis, the claimant's treating orthopedist, although not personally impressed by the long term benefits of acupuncture, stated it was possible, but very unlikely, that the claimant would benefit from the treatments. There was no evidence in Davis of possible adverse side effects from the acupuncture treatments.

As in Davis, in the present case we look beyond the novelty of the treatment in question to the medical evidence about the reasonableness of that treatment. In the present case, unlike in Davis, there are significant opinions in opposition to the form of treatment in issue. The three members of the Orthopaedic Consultants panel and the three members of the Department's committee all state in various ways that prolotherapy is not effective, is contrary to accepted professional standards and could produce serious side effects. Moreover, the observation of the Orthopaedic Consultants -- that the risk-benefit ratio hardly justifies a claimant with a chronic back pain problem driving more than 500 miles a week for prolotherapy -- seems cogent to us.

On this record, in order to join the Referee in setting aside the employer's partial denial, we would have to be able to affirmatively conclude that Dr. Ho's minority opinion about the efficacy and safety of prolotherapy is more persuasive notwithstanding the majority opinion to the contrary. Having considered the entire record, we are unable to so conclude.

ORDER

The Referee's order dated August 19, 1983 is reversed. The self-insured employer's partial denial dated June 29, 1982 is reinstated and affirmed.

BLANCHE M. KEENEY, Claimant
Gary Jones, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 83-01840
July 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of Referee Seymour's order which set aside its denial of claimant's aggravation claim for her back condition.

Claimant compensably injured her cervical and low back on March 1, 1979 while lifting a heavy cash box. The claim was accepted and closed by Determination Order which granted no award for permanent disability. On May 13, 1982 a Stipulated Order awarded claimant 80° for 25% unscheduled disability.

On January 8, 1983 claimant went on a winter outing with her family and some friends. Toward the end of the day, after consuming several hot buttered rums, claimant attempted to slide down a sloping road on a large truck inner tube. Other members of the party had worn the hill smooth by that time. Claimant has no memory of what occurred after she started sliding down the hill. Witnesses testified that claimant appeared to have passed out by the time she reached the bottom of the slope.

Claimant was taken to a hospital. The attending physician noted that she complained of pain and inability to move her legs. He diagnosed "strain + psyc overlay." Her treating physician filed a medical report form with the insurer in which he stated, "This is aggravation of previous inj (sic) that was initially stationary but still very symptomatic." The form contains no further explanation of the doctor's opinion. The only other medical report which concerns claimant's condition following the sliding incident is a report from Orthopaedic Consultants' examination of May 26, 1983. They opined that the sliding incident did not worsen claimant's condition.

The Referee relied on the report of the treating physician and found that claimant had established a compensable aggravation. We disagree. The Supreme Court said in Grable v. Weyerhaeuser, 291 Or 387 (1981):

> "We conclude that if the claimant establishes that the compensable injury is 'a material contributing cause' of his worsened condition, he has thereby necessarily established that the worsened condition is not the result of an 'independent, intervening' non industrial cause." Id at 400-1.

We find that claimant has failed to prove that her compensable injury is a material contributing cause of a worsened condition. The only evidence which links the compensable injury with claimant's allegedly worsened condition following the sledding incident is the unexplained and cryptic comment of the treating physician. Without further explanation, that statement is insufficient to carry claimant's burden of proof.

ORDER

The Referee's order dated November 18, 1983 is reversed.

JOSE LOPEZ, Claimant
Noreen Saltveit, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09336
July 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Fink's order which set aside its denial of claimant's aggravation claim for his low back condition.

Claimant compensably injured his low back on January 9, 1981 while moving tables. Claimant was diagnosed as having a lumbar

strain and was released to work on January 26, 1981. A Determination Order granted no award for permanent disability.

In July 1982 claimant saw Dr. Simpson, D.C., for continuing low back pain. Dr. Simpson advised claimant that his condition had not worsened since the time of the January injury. In September 1982 claimant moved to Texas where he spent several months fixing up a house which he owns but in which his mother holds a life estate. Claimant did not do the labor on the house, but hired help. In April 1983 claimant began seeing Dr. Carlson, D.C., in Texas. Dr. Carlson noted the January 1981 injury. He compared x-rays taken by Dr. Simpson on January 12, 1981 with x-rays taken in his office. He opined that claimant's condition was virtually unchanged.

In July 1983 claimant returned to Oregon where he again saw Dr. Simpson. In August 1983 Dr. Simpson reported:

> "I reviewed Dr. Carlson's medical reports and radiographs. A brief regional exam revealed much the same situation as in years past although it was apparent that he currently was having an acute exacerbation. I took additional radiographs and comparing them with those taken in 1981 confirmed the progression of his degenerative joint condition especially at the L4-5 level.
>
> "I treated him a few times over the succeeding weeks with only slight improvement. It was my impression that his primary problems involved irritation from the degenerating lumbar spine and not from primarily mechanical derangement. While mechanical problems were clearly in evidence, I felt they were caused by the ongoing degenerative process."

In August 1983 Dr. Peterson examined claimant at Dr. Simpson's request. He noted degenerative changes in claimant's spine. He stated no opinion on whether claimant's condition had worsened or whether the industrial injury contributed to claimant's condition at the time of his examination.

In September 1983 Dr. Duff examined claimant for SAIF. He opined:

> "This man has a lengthy medical history of back complaints over the past twenty years compatible with the changes on X-ray which demonstrate quite marked osteoarthritic change. The incident of Janaury 9, 1981, appears in retrospect to have been a rather minor exacerbation of symptoms, from which he had a rapid recovery with minimal treatment. There is no indication that his present back problems are related to that particular incident at work, and it would not appear that his work has any direct

> affect upon his symptoms now, since he reports being more symptomatic at this time after he has been out of work for over a year. There is a very mild degree of permanent physical impairment attributable to the degenerative process in his spine. No physical impairment is noted as a result of his work injury."

SAIF denied an aggravation claim on September 20, 1983.

On October 31, 1983 Dr. Pasquesi examined claimant. He opined:

> "[B]y far the greatest problem in this patient's case is the degenerative disc disease and . . . the event of 1-9-81, contributed to a small extent to his need for laying off work and receiving work at that time."

Dr. Pasquesi did not state whether claimant's industrial injury contributed to a worsening of the degenerative disc disease at the time of the injury or whether the industrial injury contributed to claimant's allegedly worsened condition at the time of the examination.

Claimant's attorney referred him to Dr. Breitenstein, D.C., for evaluation on September 27, 1983. Subsequently, Dr. Breitenstein became claimant's treating physician. Dr. Breitenstein opined:

> "It is apparent from the x-ray studies, history and exam findings that although relatively asymptomatic and dormant, a long-term, pre-existing degenerative disc condition which was further injured in January 1981. The 1981 injury, superimposed upon an asymptomatic, pre-existing chronically weakened spine, causes substantially more persistent symptoms and loss of function capacity than if imposed upon normal, healthy tissues."

The Referee accepted Dr. Breitenstein's opinion and set aside SAIF's denial of the aggravation claim. We disagree and reverse.

Claimant has preexisting degenerative disc disease which, according to his previous chiropractor became symptomatic about once per year for several years prior to his industrial injury. His injury was a strain type injury which occassioned less than one month's time loss. Dr. Duff opines that the industrial injury had no effect on claimant's degenerative disc disease. Dr. Pasquesi states the industrial injury may have contributed slightly to claimant's present condition, but he does not say whether the industrial injury contributed to any worsening of claimant's condition. Only Dr. Breitenstein supports a compensable aggravation. We are more convinced by Dr. Duff's explanation than by Dr. Breitenstein's. Accordingly, we find that claimant has failed to sustain his burden of proof.

ORDER

The Referee's order dated November 28, 1983 is reversed. The SAIF Corporation's denial dated September 20, 1983 is reinstated.

THOMAS D. PARKER, Claimant
Galton, et al., Claimant's Attorneys
Miller, et al., Defense Attorneys

WCB 80-10438
July 31, 1984
Order on Remand

The Board issued its Order on Review herein on March 2, 1983. We affirmed and adopted the Referee's order which, among other things, upheld the insurer's partial, retroactive denial of benefits beyond February 1980. 35 Van Natta 502 (1983). On claimant's petition for judicial review, the Court of Appeals remanded in part for reconsideration in light of the Supreme Court's decision (issued subsequent to the date of our order) in Bauman v. SAIF, 295 Or 788 (1983). Parker v. North Pacific Insurance Co., 66 Or App 118 (1983).

The issue before us on remand is whether the insurer was permitted to retroactively deny three previously accepted aggravation claims in February, August and November of 1980. This, in turn, depends upon whether there has been an adequate showing of "fraud, misrepresentation or other illegal activity," as contemplated by Bauman v. SAIF, supra.

Claimant was injured in July of 1979, and his claim was closed by Determination Order dated March 3, 1980, with an award for temporary total disability only. The remaining facts, as found by the court, set the background for the issue presently before us:

> "In early February 1980, claimant again injured his back. On February 13, 1980, his treating physician [Dr. Walker] wrote insurer:
>
> > '[Claimant] was seen in my office on February 4, 1980, for recurrence of back pain. The symptoms were similar to his previous back injury. He has had no other back injury since.'
>
> "On the basis of this letter, insurer accepted the February incident as an aggravation and paid time loss benefits. Claimant was released to return to work on April 28, 1980.
>
> "On August 5, 1980, and again on November 24, 1980, claimant suffered off-the-job back injuries, the first while playing softball and the second while reaching into the trunk of his car. Insurer accepted both as aggravation claims. A determination order closed all three aggravation claims on May 5, 1981, and on

the basis of a report by an examining physician that claimant was medically stationary on February 23, 1981, awarded claimant time loss for periods through February 23, 1981.

"On March 5, 1981, insurer received information from a second treating physician [Dr. Nelson] indicating that claimant's injury in February 1980 occurred while claimant was 'wrestling' with his wife.

"On May 22, 1981, insurer contacted that doctor by telephone to obtain additional information. On July 2, 1981, the doctor affirmed to insurer that 'it is medically probable that [claimant's] wrestling activities caused the time loss and medical treatment he was incurring prior to and after his visit with [me] on September 24, 1980.' Insurer then denied compensability of the February 1980 injury, and responsibility for all benefits and treatments from and after that date. Insurer asserted that recent medical evidence showed that the February 1980 injury was a new injury and that it and the two subsequent injuries were not aggravations of the 1979 injury." 66 Or App at 120-21.

The specific issue is whether claimant's failure to disclose the wrestling incident at the time he filed his claim for reopening in February of 1980 constitutes an adequate showing of "fraud, misrepresentation or other illegal activity," permitting the insurer to retroactively deny the three previously accepted aggravation claims. We hold that, under the facts and circumstances presented herein, the insurer was permitted to issue its denial.

Claimant testified that he informed Dr. Walker of the wrestling incident in question. In a letter report to claimant's attorney dated April 6, 1982, and in response to the specific inquiry of whether claimant had mentioned any wrestling incident during his office visit on February 4, 1980, Dr. Walker responded in the negative. Claimant testified that he informed the insurer's claims manager of the wrestling incident. The claims manager testified that he had no recollection of either claimant or his wife calling and specifically discussing the wrestling incident with him. We do not understand this testimony to be in the nature of a failure to recall specific incidents; rather, the claims manager was politely denying the truth of claimant's statement that he had related the incident in question. Claimant and his wife attempted to downplay the physical nature of the wrestling incident, for obvious reasons. The Referee concluded: "Weighing comments in the record . . . as well as my impressions of claimant after observing him as a witness, I conclude that claimant probably did 'wrestle' playfully with his wife as he originally reported to Dr. Nelson." The Referee also concluded that the insurer's claims manager had not actually been informed

of the wrestling incident prior to its mention in Dr. Nelson's report. These statements by the Referee indicate that he viewed claimant's testimony with caution, and suggest that claimant was not entirely credible.

Claimant described the onset of symptoms which he experienced as a result of the wrestling incident. He experienced the immediate onset of sharp pain and found it necessary to lie down in bed with a heating pad. It is hard to imagine that claimant merely forgot to mention this incident when he reported to Dr. Walker the following day.

A failure to disclose a previous injury is one type of misrepresentation contemplated by Bauman v. SAIF, supra. Skinner v. SAIF, 66 Or App 467, 470 (1984). Claimant argues that this case is distinguishable from Skinner because that claimant actually denied any previous injury to her neck (the site of her industrial injury), whereas the evidence in this case establishes merely the claimant's failure to disclose the incident in question. The ultimate inquiry in either case, however, is the claimant's reason for denying a previous or intervening injury, on the one hand, or failing to disclose such an injury without affirmatively denying its occurrence, on the other hand. In both cases, the reason could be an innocent failure to recall, as opposed to active concealment. For purposes of determining whether an insurer should be permitted to retroactively deny benefits, the claimant's affirmative denial in Skinner and this claimant's failure to disclose a material incident appear strikingly similar, if not identical. See also Robert D. Craig, 36 Van Natta 355 (1984) (a claimant's failure to relate a history of a potentially significant intervening injury can be a type of misrepresentation contemplated by Bauman).

We understand claimant's argument on remand to be that the burden of proof is upon the insurer to establish "fraud, misrepresentation or other illegal activity" within the meaning of Bauman v. SAIF, supra. We addressed the burden of proof issue in Benjamin G. Parker, 36 Van Natta 69, 70 (1984):

> "[W]e understand the burden of proof rule in cases involving backup denials to be that the burden of going forward with some evidence of fraud, misrepresentation or other illegal activity lies with the insurer. Once this burden of going forward is met, it is the claimant's ultimate burden to prove the compensability of the claim."

The burden of proof is upon the claimant to establish the compensability of a claim. The presence or absence of fraud or misrepresentation may or may not be dispositive of the compensability issue. Compare Skinner v. SAIF, supra (claimant sustained burden of proving compensability of her neck condition despite her misrepresentation in the nature of a failure to disclose previous injury), with Wilkins v. SAIF, 66 Or App 420 (1984) (claimant asserted a claim for an accident that never occurred, i.e. the claim was entirely fraudulent).

The "burden of going forward," or the duty of going forward

with some evidence of a particular fact in issue, differs from the ultimate burden of proof, or the burden of persuading the trier of fact that the alleged fact is true. The distinction is discussed at length by Professor McCormick in his Handbook of the Law of Evidence, §§ 336-41 (2d ed. 1972). In response to the question, how strongly persuasive must the evidence be to satisfy the burden of producing evidence, McCormick states:

> "The evidence must be such that a reasonable man could draw from it the inference of the existence of the particular fact to be proved or, as put conversely by one federal court, 'if there is substantial evidence opposed to the [motion for directed verdict], that is evidence of such quality and weight that reasonable and fair-minded men in the exercise of impartial judgment might reach different conclusions, the [motion] should be denied.'" McCormick, supra at 789-90.

The question, therefore, is, if this case were being tried to a court and jury, whether there would be sufficient evidence of "fraud, misrepresentation or other illegal activity" to avoid a motion for directed verdict and have the issue of claimant's possible fraud or misrepresentation submitted to the jury. We believe that there is. Accordingly, the insurer has satisfied its duty in this case.

Once the burden of going forward with some evidence of "fraud, misrepresentation or other illegal activity" has been met by the insurer, it is the claimant's burden to prove that the claim is compensable. Benjamin G. Parker, supra. We have previously decided that claimant has failed to sustain this burden of proof. Thomas T. Parker, supra. Therefore, we reaffirm our Order on Review, in which we affirmed the Referee's order upholding the insurer's partial, backup denial.

ORDER

On remand the Board adheres to and reaffirms its March 2, 1983 Order on Review, as supplemented herein.

RAYMOND L. PORTER, Claimant
Burt, et al., Claimant's Attorneys
Keith Skelton, Defense Attorney
Norman Kelley, Ass't. Atty. Gen.

WCB 83-00626
July 31, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Nichols' order which affirmed the decision of the Director of the Workers' Compensation Department which denied claimant's request for reimbursement and further academic assistance. Claimant contends the Director's decision was an abuse of discretion. On review, the insurer agrees with claimant's contention.

Prior to the Board's involvement, the Director of the Workers' Compensation Department upheld the Field Services Division's decision not to provide further training to claimant. At the hearing before the Referee, the insurer's counsel stated

that neither the Director nor the Department had consulted with him. Further, counsel did not see how he could represent the Department as he was required to under OAR 436-61-970(1). It was the opinion of the insurer's counsel that the Department was in default. The Referee approved the Director's decision, finding that the Director did not abuse his discretion.

Claimant requested Board review.

Before reaching the merits, the Board advised the Director of the Workers' Compensation Department of the current status of this case. Noting that the insurer's counsel disagreed with the requirement that he represent the Department in this matter, we requested that the Department advise us of the Department's position.

The Department notified the Board that it was unaware of the position taken by the insurer's counsel at hearing or on appeal. With its response, the Department enclosed an affidavit from a vocational consultant for the Department. In her affidavit the consultant referred to placement assistance offered to claimant, some of which immediately preceded claimant's hearing, which resulted in his employment approximately 10 days post-hearing.

Contending the affidavit illustrated that the case had been incompletely or otherwise insufficiently developed, the Department requested that the case be remanded and that it be given actual notice of the hearing.

Claimant objected to the affidavit's admission, arguing that it was untimely offered with no opportunity for cross-examination.

The Department responded that the affidavit was not intended to be considered in connection with the merits of the case. It was expressly intended to support the Department's motion for remand.

In arriving at our conclusion, we note that we are precluded from considering the affidavit as evidence. ORS 656.295(5). However, we are authorized to remand should we find that the record was "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). We so find. Therefore, we grant the Department's motion for remand.

Accordingly, this case shall be remanded to the Referee for hearing. The Department shall be given actual notice of the time and place of hearing. At that time all parties shall have the opportunity to present any and all evidence which pertains to the Director's decision.

ORDER

The Referee's order dated May 24, 1983 is vacated. This case is remanded to the Referee for further proceedings consistent with this order.

DONALD E. SALMON, Claimant
Robert Chapman, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-02400
July 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Mongrain's order which: (1) set aside its partial denial of medical services; (2) assessed a penalty because of SAIF's untimely denial; and (3) concluded that SAIF was not entitled to a setoff against future benefits in the amount of $143.24, which was advanced to claimant for travel from his home in Medford for an independent medical examination in Portland, even though claimant did not actually go to Portland for that examination.

The Board affirms and adopts the order of the Referee on the medical service and penalty issues.

We reverse on the setoff issue. SAIF advanced claimant $143.24 for travel expenses when it notified him that he was to attend an independent medical examination in Portland. Claimant did not report for such an examination at the time of the first scheduled appointment. Another appointment was scheduled, and claimant again failed to attend it. Claimant presents virtually no argument, and certainly no persuasive argument, about why he should be able to retain money that was advanced to him expressly on the condition that he attend an independent medical examination in view of the nonocurrence of that condition. We conclude that fundamental fairness dictates the conclusions that claimant is not entitled to retain travel expenses for a trip that was never made and, therefore, that SAIF should be entitled to setoff those travel expenses against future benefits.

ORDER

The Referee's order dated November 26, 1983 is affirmed in part and reversed in part. That portion which denied the setoff requested by the SAIF Corporation is reversed and, in lieu thereof, SAIF may setoff $143.24 against future benefits that may become due and payable on this claim. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $375 for services rendered on Board review in connection with the medical services and penalty issues, to be paid by the SAIF Corporation.

LOIS V. SEXTON, Claimant
Emmons, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-09417
July 31, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of that portion of Referee Daron's order which set aside its partial denial of pain clinic treatment and ordered it to pay temporary total disability benefits during claimant's participation in a pain clinic program. The insurer argues that the Referee's order is internally inconsistent, on the one hand upholding its partial denial of claimant's psychological condition as a compensable consequence of her injury claim, while on the other hand ordering

pain clinic treatment which is partially psychological in nature. The insurer also contends that, in any event, time loss is not warranted while claimant receives pain clinic treatment.

The insurer's inconsistency argument has a certain appeal, but we find the present case analogous to Rebecca Hackett, 34 Van Natta 460 (1982), aff'd without opinion, 60 Or App 328 (1982). In Hackett, we reasoned that medical treatment of compensable and noncompensable conditions is sometimes inseparable and thus that incidental/inseparable treatment of a noncompensable condition should sometimes be provided under ORS 656.245. We find that reasoning applicable in this case. Here, claimant's psychological condition has been found to be not work-related or injury-related. However, according to the preponderance of medical evidence, in order to treat claimant's compensable low back injury, her noncompensable psychological problem must also be addressed. Without a pain clinic program, which necessarily incorporates psychological counseling among its multi-disciplinary approach, claimant would be unable to cope with her pain and physical complaints. See also Fitzpatrick v. SAIF, 67 Or App 450 (1984).

Subsequent to the issuance of the Referee's order, the Court of Appeals ruled in Hutchinson v. Louisiana-Pacific Corporation, 67 Or App 577 (1984), that a claimant is entitled to a reopening and reconsideration of his claim only if he establishes a worsening of his condition or if he ceases to be enrolled and actively engaged in an authorized vocational rehabilitation program. The present case is analogous to Hutchinson in that the claim was appropriately closed and claimant has not established a worsening of her condition. Consequently, she is not entitled to time loss while participating in the pain clinic program.

ORDER

The Referee's order dated August 24, 1983 is reversed in part and affirmed in part. That portion which ordered the insurer to pay temporary total disability benefits during claimant's participation in a pain clinic program is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

TEC EQUIPMENT, Inc., Employer
DAVID A. THOMPSON, Individual
Drakulich & Carlson, Attorneys
David Force, Attorney
Meyers & Terrall, Attorneys
SAIF Corp Legal, Attorney
Jim Russell, Attorney, Dept. of Justice

WCB 82-11445
July 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

In these consolidated cases, the noncomplying employer, TEC Equipment, Inc. (TEC), requests and the Workers' Compensation Department cross-requests review of Referee Mulder's orders which set aside the denials of responsibility issued by the SAIF Corporation as processing agent for the noncomplying employer and upheld the denials of responsibility issued by SAIF as insurer for Bear Springs Forest Products, Inc. (Bear Springs). The main issue is whether SAIF is responsible for these claims in its role as

processing agent for the noncomplying employer or, instead, whether SAIF is responsible for these claims in its role as insurer for Bear Springs because of the provisions of ORS 656.029. Subsidiary issues are raised concerning the Referee's awards of attorney fees.

Most of the facts were stipulated at hearing. All of the claimants involved in these proceedings were employed as truck drivers by TEC. On October 12, 1982 claimants Potter and Rogers sustained compensable injuries while working for TEC. On October 14, 1982 claimants Lambert and Welborn sustained compensable injuries while working for TEC. In October 1982, when claimants were injured, TEC was a noncomplying employer.

TEC is an Oregon corporation engaged in the business of hauling lumber and wood products. Bear Springs is an Oregon corporation engaged in the business of purchasing lumber and wood products and reselling those products to businesses throughout the United States. Bear Springs and TEC are separate corporations. Bear Springs did not employ the claimants, nor did it have any direct right of control over the claimants or any TEC employe. All of the claimants were injured while hauling lumber for Bear Springs pursuant to a verbal contract between Bear Springs and TEC. Bear Springs relies exclusively on other businesses to transport products for it, TEC being only one of several such businesses. Bear Springs does not advertise hauling contracts for competitive bidding. Rather, contracts between TEC and Bear Springs were formed by telephone and confirmed by invoice or memoranda. In October 1982, when claimants were injured, Bear Springs was a complying employer insured by the SAIF Corporation.

All claimants filed claims. The Workers' Compensation Department referred the claims to SAIF pursuant to ORS 656.029 as insurer for Bear Springs. SAIF denied all of the claims on the grounds that there was a question of whether SAIF was responsible as insurer for Bear Springs or whether SAIF was responsible as processing agent for the noncomplying employer. SAIF then submitted the claims to the Workers' Compensation Department for issuance of orders designating a paying agent pursuant to ORS 656.307. The Department issued orders designating Bear Springs/SAIF as the paying agent, and the responsibility question was referred for a hearing.

All references to ORS chapter 656 are to the law in effect on the dates of injury in October 1982. ORS 656.202(1).

ORS 656.029 provides in part:

> "(1) If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let has qualified either as a carrier-insured employer or a self-insured employer.

"(2) If the person to whom the contract is let performs the work without the assistance of others, that person is subject to this chapter as a subject worker of the person letting the contract unless that person and the person letting the contract jointly file with the insurer or self-insured employer a declaration stating that the services rendered under the contract are rendered as those of an independent contractor."

The Referee found: (1) that Bear Springs was a "person" engaged in a business and that Bear Springs let a contract to TEC involving the performance of labor, but that it was to be performed without the assistance of others; (2) that ORS 656.029(2) did not apply because it was meant to apply mainly to the construction industry, although it could be applied to other trades if the "proper prime/sub elements were present"; and (3) that the labor being performed by the claimants was not "in the class of activity which the legislature contemplated" as requiring the filing of a declaration pursuant to ORS 656.029. The Referee therefore concluded that SAIF was responsible as processing agent for the noncomplying employer.

We disagree. Many of the parties' arguments in these cases have been considered at length and resolved by our decisions in Richard F. Erzen, 36 Van Natta 218 (1984), and Richard O. Hampton, 36 Van Natta 230 (1984), which point toward the opposite conclusion than the Referee reached. In light of Erzen and Hampton, the question in this case is whether there is any unique reason here why ORS 656.029 should not be applied to make Bear Springs/SAIF responsible for the claimants' injuries.

We agree with the Referee's finding that, pursuant to ORS 656.005(21), TEC constitutes a "person" to which ORS 656.029 is applicable. Erzen, supra, 36 Van Natta at 220-21. However, the Referee's finding that ORS 656.029(1) does not apply because the labor performed by TEC was not done with the assistance of others is incorrect. The Referee concluded: "The drivers are TEC." We disagree with this analysis.

Claimants Potter and Rogers had been employed by TEC for one to two months before the date of their injuries. Both were hired by Jim Reed, the dispatcher at TEC; both were hired to work at the rate of 9 cents per mile while driving and $6 per hour for shop and maintenance time. Claimants Welborn and Lambert were hired by TEC immediately before the date of their truck accident. They were to receive 9 cents per mile while driving. Claimant Welborn was hired by David Thompson, president of TEC. Taxes and social security were withheld from the claimants' pay by TEC. There is nothing in the record indicating that claimants had any interest in TEC other than as employes working for wages. Thus, assuming that it could be relevant, claimants had no ownership interest of any kind in TEC and, therefore, it cannot be said that, "the drivers [i.e., the claimants] are TEC."

The next question is whether the contract let by Bear Springs to TEC was a contract "involving the performance of labor." Bear Springs argues that the contract between it and TEC did not call for the performance of labor, but for the transportation of wood.

For this proposition, Bear Springs cites Bowser v. SIAC, 182 Or 42 (1947), and Cox v. SIAC, 168 Or 508 (1942). In Cox, the claimant's father hired Randall to haul wood for $1 per cord. Randall then hired claimant to assist him and paid him 15 cents per cord. Claimant was injured while assisting Randall. The court found that Randall was an independent contractor and that claimant was his employe. Interpreting former OCLA §102-1703, which was somewhat akin to ORS 656.029, the court stated:

> "The contract between [claimant's father] and Randall did not call primarily for the performance of labor, but for the transportation of the wood. The labor was incidental. The use of the truck was what Cox wanted." 168 Or at 513.

In Bowser v. SIAC, supra, claimant was a log hauler who was hauling logs for a company at a set price per thousand board feet when he was injured. The court found claimant to be an employe of the logging company because he was hauling logs rather than performing labor.

Bear Springs argues that, because the court in Cox and Bowser was construing language "virtually identical to that now found in ORS 656.029," that ORS 656.029 is not applicable in the present case because Bear Springs contracted with TEC not for the performance of labor, but for the hauling of wood products. We disagree. The statute in effect at the time of the Bowser and Cox decisions provided that the "principal purpose" of the contract must be the performance of labor; this language was emphasized by the court in both cases. However, the version of ORS 656.029 in effect on the date of claimants' injuries does not contain the qualifying language about "the principal purpose [being] the performance of labor," but states only: "If any person engaged in a business . . . lets a contract involving the performance of labor . . ." (Emphasis added.) Thus, the statute no longer requires that the principal purpose of the contract be the performance of labor, but only that the contract "involves" the performance of labor.

The significance of this difference between the older and the newer statutory language is illustrated by Robert E. Becker, 36 Van Natta 782 (1984). In that case the claimant was employed by D & F Trucking as a dump truck driver. D & F contracted with Eldridge whereby D & F agreed to furnish materials to a job site in Washington. The claimant's primary responsibility was the transportation of loads of riprap from a quarry in Oregon to the Washington job site. The claimant was injured in the course of his employment. D & F was noncomplying. Eldridge argued that ORS 656.029 was not applicable because the contract was for the transportation of materials rather than the performance of labor. We disagreed and found that the transportation of rock by means of a dump truck in the performance of a contract meant that contract "involved" the performance of labor as contemplated in ORS 656.029.

There is no meaningful difference between the transportation of riprap by truck that was presented in Becker and the transportation of wood products by truck that is presented in these cases. We find our decision in Becker and the lack of the prior statutory "primary purpose" language in ORS 656.029 to be

dispositive. Bowser and Cox are, therefore, inapplicable. Although the contract between Bear Springs and TEC may have been primarily for the hauling of materials, it clearly involved the performance of labor on the part of the claimants in these cases.

In summary, with regard to ORS 656.029(1), we conclude that Bear Springs is: (1) a person; (2) engaged in a business and subject to ORS chapter 656 as an employer which: (3) let a contract involving the performance of labor; and (4) that such labor was performed with the assistance of others (the claimants). Since all of these requirements have been met, ORS 656.029(1) mandates that all persons engaged in the performance of the contract between Bear Springs and TEC are deemed to be subject workers of Bear Springs (the person letting the contract) because TEC had not qualified as an insured or self-insured employer. (Since the contract was performed with the assistance of others, the additional requirements of ORS 656.029(2) are not applicable.) Therefore, ORS 656.029(1) requires the conclusion that Bear Springs/SAIF is responsible for the claims here in issue by operation of law. Although we noted in Richard O. Hampton, supra, that it might be possible that in some case we would find the purpose of the contract to be so totally unrelated to the business purpose of the "prime" contractor that applicaton of ORS 656.029 would be stretched to the breaking point, this is not such a case.

We turn to the subsidiary attorney fee questions. The Referee awarded attorney Dusterhoff who represented claimant Welborn a fee of $700. We find this fee unwarranted considering the facts that Mr. Dusterhoff was not present when the hearing began, he only attended the hearing for a very short period of time and he did not even participate in the hearing. Apparently attorney Dusterhoff was not involved in the drafting of the stipulated facts, and, as related by attorney Carlson:

> "Mr. Dusterhoff has left the hearing. He did indicate, however, that I could represent his interests concerning Mr. Welborn, since Mr. Welborn and Mr. Lambert are virtually in identical positions."

Under these circumstances we find that attorney Dusterhoff is entitled to no attorney fee because he did not actively or meaningfully participate at the hearing within the meaning of OAR 438-47-090(1).

The attorney representing claimants Potter and Rogers on this review argues that an attorney fee larger than $1,000 should have been awarded by the Referee since their attorney "prevailed" on two claims rather than on just one claim. However, it must be remembered that there was no question of compensability involved in any of the claims in this case; the only issue was responsibility. Moreover, the cases were consolidated because of common issues of law and fact; so whether an attorney prevailed on one claim or two claims under these circumstances would not seem to be particularly significant. After having examined the record, we conclude that the $1,000 attorney fee awarded the attorney for claimants Potter and Rogers is sufficient.

Pursuant to Robert Heilman, 34 Van Natta 1487 (1982), claimants' (Potter and Rogers) attorney is entitled to no attorney fee on Board review.

ORDER

The Referee's orders dated October 4, 1983 and November 15, 1983 are affirmed in part and reversed in part. Those portions of the Referee's orders which set aside the denials issued by the SAIF Corporation as processing agent for the noncomplying employer are reversed and, in lieu thereof, those portions of SAIF's denials are reinstated and affirmed. Those portions of the Referee's orders which upheld the denials issues by SAIF as insurer for Bear Springs Forest Products, Inc. are reversed and, in lieu thereof, these claims are remanded to SAIF/Bear Springs for acceptance and processing. That portion of the Referee's order which awarded attorney Dusterhoff a fee of $700 is reversed. The other attorney fees awarded by the Referee are affirmed with the modification that they are to be paid by SAIF/Bear Springs.

DOUGLAS J. WINDRESS, Claimant
Williamson, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01168
July 31, 1984
Order on Reconsideration

On June 1, 1984 claimant forwarded a letter to the Board contending his attorney had not received sufficient time to prepare a respondent's brief and that the Board's Order on Review issued May 11, 1984 was premature. The Board issued its Order of Abatement on June 6, 1984, requesting an explanation from claimant's attorney of record as to why no respondent's brief had been filed on claimant's behalf. The Board further requested that the SAIF Corporation respond to claimant's contentions. On June 27, 1984, after reviewing the parties' responses to the Board's Order of Abatement, the Board decided to reconsider its Order on Review and allowed the parties an opportunity to submit briefs.

The Board has received the parties' briefs and has reviewed the arguments raised therein. On reconsideration, the Board adheres to its former order.

IT IS SO ORDERED.

BILL R. ANDERSON, Claimant
January Roeschlaub, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-02459
August 7, 1984
Order on Review (Remanding)

On review of the Board's Order on Review dated June 29, 1983, the Court of Appeals modified the Board's order and remanded to the Board for further proceedings.

At hearing, the Referee ordered:

> "IT IS THEREFORE ORDERED that the denial of claimant's aggravation be and the same is hereby disapproved and SAIF Corporation is Ordered to accept said claim and reopen the same at the time claimant submits to the surgery proposed by Dr. Poulson."

On Board review, the only issue was the correct date for reopening the claim. The Board affirmed and adopted the Referee's

order. The Court of Appeals, in a per curiam opinion, modified the "Order" portion of the Referee's order to eliminate the words " * * * and reopen the same at the time claimant submits to the surgery proposed by Dr. Poulson." The court remanded for further proceedings to "determine what compensation, if any, claimant is entitled." Anderson v. SAIF, 68 Or App 47, 48 (1984). On remand, we remand to the Hearings Division for further proceedings consistent with the Court of Appeals' decision.

ORDER

The case is remanded to the Hearings Division for proceedings consistent with the Court of Appeals' decision.

LAURIE R. CLIFFORD, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-06230
August 7, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Braverman's order which found the claim was not prematurely closed. Claimant also seeks remand for the Referee to consider pain center records. In the alternative, claimant argues that she is entitled to a greater award of unscheduled disability than the 32° for 10% unscheduled disability granted by a Determination Order which the Referee upheld. The insurer cross-requests review of those portions of the Referee's order which ordered the claim reopened for pain center treatments.

The Board affirms and adopts those portions of the Referee's order which found that the claim was not prematurely closed.

After the Referee's order, the Court of Appeals, in Hutchinson v. Louisiana-Pacific, 67 Or App 577 (1984), held that a claimant is not automatically entitled to reopening upon entry into a pain center program. The court stated:

> "A claimant is entitled to a reopening and a redetermination of his claim only if he establishes a worsening of his condition or if he ceases to be enrolled and actively engaged in an authorized vocational rehabilitation program." Id at 581.

Claimant was not enrolled in a vocational rehabilitation program nor has she established a compensable worsening of her condition after January 17, 1983 when she became stationary. Accordingly, she is not entitled to reopening for the pain center treatment.

Claimant moves to remand for consideration of the complete pain center records. At hearing, claimant's attorney requested that the Referee keep the record open pending receipt of these records. The insurer's attorney agreed. The Referee stated he would keep the record open pending receipt of the records. The pain center records were apparently not received prior to the Referee's order. Claimant argues that the extent of her disability cannot be fully evaluated without those records. We agree and, therefore, find that on the issue of extent of

disability the record has been incompletely developed. ORS 656.295(5). Accordingly, we remand to the Hearings Division for consideration of extent of disability only.

ORDER

The Referee's order dated January 10, 1984 is affirmed in part, and reversed in part. That portion of the Referee's order finding the claim was not prematurely closed is affirmed. That portion of the Referee's order ordering the claim reopened during pain center treatment is reversed. The claim is remanded to the Hearings Division for further proceedings consistent with this order.

GLENN H. MATHIS, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-10490
August 7, 1984
Order Denying Motion to Dismiss

The SAIF Corporation moves to dismiss claimant's request for Board review on the grounds that claimant failed to serve a copy of the request for review on the employer within 30 days of the date of the Referee's order. See ORS 656.289(3), 656.295(2).

The Referee's order was entered on June 1, 1984. Claimant timely requested review within 30 days of the date of the Referee's order. See ORS 656.289(3); OAR 438-11-005(2) (formerly OAR 436-83-700(2)).

SAIF alleges that the employer neither received a copy of claimant's request for review, nor received actual notice of the request, within the statutory period. The record reveals, however, that SAIF and its counsel received timely notice of claimant's request for review. The Court of Appeals has stated:

> "We hold that compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." Argonaut Insurance Company v. King, 63 Or App 847, 852 (1983).

However, the court has also held that service on an employer's insurer is sufficient to provide notice to the employer. Nollen v. SAIF, 23 Or App 420 (1975). Because SAIF received actual notice of the request for review within 30 days, the employer was on notice of the request for review despite the fact that it was not individually served. Accordingly, SAIF's motion to dismiss is denied.

ORDER

The SAIF Corporation's motion to dismiss is denied.

DOYLE L. MITCHELL, Claimant
Evohl Malagon, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 83-05967 & 83-05968
August 7, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Foster's order which found it responsible for a bill for a medical examination. On review, the insurer contends it is not responsible for payment of the bill because the medical examination was for litigation purposes. We agree and reverse the Referee.

Claimant received 10% permanent disability for a low back injury by a Determination Order dated June 19, 1979. Claimant requested a hearing, seeking additional temporary and permanent disability, a penalty for delay in payment of compensation and attorney fees. In addition, claimant subsequently filed an aggravation claim.

On October 24, 1979 claimant was examined by Dr. Donald T. Smith, neurologist. Claimant had been referred to Dr. Smith by claimant's counsel, who requested that the insurer be billed for the examination.

By letter dated October 29, 1979 Dr. Smith opined that claimant was probably suffering from a chronic strain-sprain pattern associated with degenerative arthritis of the lumbar spine and residual changes associated with previous surgery. The doctor believed that claimant should be considered for a myelogram to determine the status of his lower spinal canal. Dr. Smith encouraged claimant to begin a "definite weight management program" and instructed him in back strengthening exercises as "an integral part of any longterm treating program." If claimant wished to proceed with the myelographic study, Dr. Smith stated that he would make arrangements.

In a November 19, 1979 letter to the insurer, claimant's counsel enclosed a copy of Dr. Smith's report and made an offer of settlement.

By letter dated November 20, 1979 the insurer requested a current status report from Dr. Smith and asked the doctor if claimant had been seen since his initial examination. "Beverly," purportedly of Dr. Smith's office, advised the insurer that claimant had not been seen again. "Beverly" noted that a myelogram had been recommended and would be scheduled with the insurer's written authorization, if claimant desired.

By Stipulations dated June 20, 1980 and November 5, 1980, claimant's claims were settled. In consideration for additional temporary and permanent disability, plus a penalty and attorney fees, claimant's claim remained in closed status and claimant agreed to waive his right to request a hearing on the Determination Order and the aggravation claim. Dr. Smith's bill was not mentioned.

After the insurer refused to pay his bill, Dr. Smith sought payment from claimant's counsel. Thereafter, claimant filed a request for hearing.

At hearing the parties argued on the record without any testimony. The Referee found Dr. Smith's bill compensable, reasoning that although Dr. Smith had seen claimant only once, he had recommended treatment. Further, the Referee found it persuasive that the insurer had prepared the Stipulations, which had not specifically excluded Dr. Smith's bill.

A doctor's fee for writing a report is the responsibility of the insurer if the report is written in connection with compensable treatment. Clara M. Peoples, 31 Van Natta 134 (1981). However, a medical bill stemming from a consultation for the purpose of litigation preparation and not treatment is not compensable. Joean Cisco, 34 Van Natta 1030 (1982).

We are not persuaded that Dr. Smith's bill was for treatment rather than litigation purposes. Claimant only saw Dr. Smith once. The examination was arranged by claimant's counsel. Dr. Smith merely encouraged claimant to start a weight management program and instructed him on back strengthening exercises. The record indicates that claimant had received similar advice from previous physicians. Additionally, "Beverly's" interpretation aside, Dr. Smith reported that a myelographic study should be considered, dependent upon claimant's wishes. Claimant's failure to return to see Dr. Smith indicates his disinclination to submit to such a study. Without question, an expression of claimant's intent or considerations in seeking Dr. Smith's services would have been enlightening. However, we are foreclosed from such an insight because claimant was not present at the hearing.

In reaching our conclusion we do not find it particularly important that the stipulations failed to mention Dr. Smith's medical bill. The stipulations specifically refer to the issues presented in claimant's requests for hearing. The doctor's bill was not referred to as an issue in claimant's requests for hearing and is omitted from the stipulations. Moreover, the stipulations do not expressly settle any and all claims, or possible claims, then in existence. Consequently, it follows that Dr. Smith's bill is a separate issue, not affected by the stipulations' provisions.

ORDER

The Referee's order dated January 12, 1984 is reversed. The medical bill of Dr. Smith for his October 24, 1979 examination is not compensable.

MARY K. COBURN, Claimant
Gatti & Gatti, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-06608
August 10, 1984
Interim Order of Remand

The insurer requests review of Referee Foster's order which set aside its denial of claimant's occupational disease claim for her right shoulder and arm condition.

In reviewing this case, the Board was unable to correlate the videotape evidence (Exhibit 14) with the parties' arguments and the issue presented. Since we doubt that the videotape provided for Board review is an accurate reproduction of that shown at hearing, we remand this case to the Referee to view Exhibit 14,

obtain an accurate copy if necessary, recertify the record for Board review, and then return this case to the Board for further processing.

ORDER

This matter is remanded to the Referee for further action as provided herein. The Board retains jurisdiction over this case during the interim.

DELBERT LAWSON, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Brian L. Pocock, Defense Attorney
Miller, et al., Defense Attorneys

WCB 82-10501 & 82-11235
August 10, 1984
Order Denying Motion to Dismiss

The SAIF Corporation moves to dismiss Argonaut Insurance's request for Board review on the grounds that Argonaut failed to serve a copy of its request for review on SAIF within 30 days of the date of the Referee's order herein, and that SAIF failed to receive actual notice of Argonaut's request for review within the statutory period. See ORS 656.289(3); 656.295(2).

The Referee's order was entered on May 16, 1984. Argonaut requested review within 30 days of the date of the Referee's order by hand delivering the request for review to the Workers' Compensation Board offices on June 15, 1984, the 30th day. See OAR 438-11-005.

SAIF did not receive a copy of the request for review until June 16, 1984 when a copy of the request for review was hand delivered to the home of SAIF's attorney. SAIF also received a copy of the request for review by mail on June 18, 1984. The copy received by mail was postmarked June 16, 1984. SAIF argues the request for review was not mailed within 30 days and it did not receive actual notice within 30 days, and that such a request is late and does not satisfy ORS 656.295. Argonaut Insurance v. King, 63 Or App 847 (1983).

Argonaut has provided affidavits which indicate that, despite the June 16, 1984 postmark, a copy of the request for review was mailed to SAIF on the evening of Friday, June 15, 1984. Based on the affidavits, we find that Argonaut mailed a copy of the request for review to SAIF on June 15, 1984. Mailing on the 30th day is sufficient to perfect a timely request for review. OAR 438-11-005. Accordingly, we have jurisdiction to consider Argonaut's request for review.

ORDER

The SAIF Corporation's motion to dismiss for lack of jurisdiction is denied.

MILO L. REESE, Claimant
Olson Law Firm, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Cheney & Kelley, Defense Attorneys

WCB 82-05169
August 10, 1984
Order on Remand

On review of the Board's Order on Review dated April 14, 1983, the Court of Appeals reversed the Board's order.

Now, therefore, the above-referenced Board order is vacated, and this claim is remanded to the insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

JOHN E. SUTTON, Claimant
Doblie & McSwain, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 83-03867
August 10, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Quillinan's order which upheld the insurer's partial denial of claimant's current low back condition. The primary issue on review is compensability.

Claimant also raises a procedural issue, assigning as error the Referee's refusal to reopen the evidentiary record after issuance of her order. Claimant seeks an order remanding to the Referee for further proceedings and further evidence taking on the issue of the compensability of his current condition as an occupational disease. ORS 656.295(5).

The Referee held that claimant failed to satisfy his burden of proving that his 1981 industrial injury is a material contributing cause of his current low back condition. The Referee concluded that claimant's work activity as a sheet turner, beginning in November of 1981, was a "causative element in claimant's continuing low back strain." Seizing upon this finding, claimant requested that the Referee reopen the record in order to allow him to litigate an occupational disease theory of compensability. Claimant asserted surprise "based on the evolution of the hearing and the Referee's findings . . . ."

The Referee correctly declined to reopen the record. Claimant's medical and employment histories were, presumably, well known to claimant's attorney before the hearing. Equipped with this knowledge, it was incumbent upon claimant to assert and develop his theories of compensability prior to and at the hearing, rather than going forward with one theory and, upon receiving an adverse decision, claiming "surprise."

For the same reasons, it would be totally inappropriate to remand for further evidence taking. In addition, claimant does not tender any additional evidence in support of this possible occupational disease theory of compensability; claimant merely requests that he be permitted to develop evidence in support of this theory on remand. We have previously denied remand under similar circumstances. Martha Mount, 35 Van Natta 557 (1983). Contrary to claimant's assertions, the record in this case has not been "improperly, incompletely or otherwise insufficiently

developed or heard" such as to warrant remand. ORS 656.295(5). Nor is there any "compelling basis" for remand under the facts and circumstances presented herein. See Buster v. Chase Bag Co., 14 Or App 323, 332 (1973); see also Gallea v. Willamette Industries, 56 Or App 763, 768 (1982); Russell v. A. & D. Terminals, 50 Or App 27, 30-31 (1981).

On the merits of the compensability issue, we affirm the Referee's order.

ORDER

The Referee's order dated October 28, 1983 is affirmed.

CLARENCE R. SWAHLEN, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-07457
August 10, 1984
Order on Remand

On review of the Board's Order on Review dated March 2, 1983, the Court of Appeals reversed the Board's order and remanded for an order requiring the self-insured employer to repay the amount deducted as an offset.

Now, therefore, the above-referenced Board order is vacated, and this claim is remanded to the employer for repayment of the amount deducted as an offset.

IT IS SO ORDERED.

JONATHAN WALLACE, Claimant
Olson Law Firm, Claimant's Attorneys
Cheney & Kelley, Defense Attorneys

WCB 81-11546
August 10, 1984
Order on Remand

On review of the Board's Order on Review dated April 14, 1983, the Court of Appeals reversed the Board's order.

Now, therefore, the above-referenced Board order is vacated, and this claim is remanded to the insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

NORMAN WRIGHT, Claimant
Lyle C. Velure, Claimant's Attorney
Cheney & Kelley, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-01105 & 82-02772
August 10, 1984
Order on Remand

On review of the Board's Order on Review dated April 14, 1983, the Court of Appeals reversed the Board's Order.

Now, therefore, the above-referenced Board Order is vacated, and this claim is remanded to the insurer for acceptance and payment of benefits in accordance with law.

IT IS SO ORDERED.

RONALD R. BRENNEMAN, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01759
August 14, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Baker's order which dismissed his hearing request on the ground that claimant had failed to establish that the SAIF Corporation had denied or delayed payment of chiropractic services. The Referee also ruled that claimant had failed to establish entitlement to relief with respect to an issue concerning a transcutaneous nerve stimulator (TNS) unit.

The issue presented is whether, when an employer/insurer requests that a medical services provider justify treatments in excess of the administrative guidelines stated in OAR 436-69-201(2)(a), and the provider fails or refuses to respond, unpaid billings for treatment in excess of the administrative guidelines are in "de facto" denied status, thereby entitling a claimant to request a hearing contesting the employer/insurer's nonpayment for treatment in excess of the guidelines.

Briefly, the material facts are as follows. Claimant sustained a compensable back injury in April 1982 which was accepted as a disabling injury. Claimant came under the care of Dr. Llewellyn, a chiropractor, who rendered spinal manipulation treatment. Dr. Llewellyn also prescribed a TNS unit, which he provided directly to claimant. Dr. Llewellyn submitted bills, on about a monthly basis, to SAIF for claimant's chiropractic treatment and for rental charges for the TNS unit claimant received from Dr. Llewellyn.

Starting in October 1982 and continuing into 1983, SAIF responded to all of Dr. Llewellyn's bills by paying a portion, not paying a portion, and requesting more information from Dr. Llewellyn about the unpaid portion. The reason for an unpaid portion and for the request for additional information was the same -- that Dr. Llewellyn's treatments were in excess of those allowed by the Workers' Compensation Department rules governing medical services.

The pertinent rule, OAR 436-69-201(2)(a), then provided:

> "Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 24 office visits by any and all attending physicians in the first 60 days from first date of treatment, and 4 visits a month thereafter."

(As subsequently amended by WCD Admin. Order 1-1984, effective January 16, 1984, OAR 436-69-201(2)(a) presently provides: "The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first

60 days from first date of treatment, and 2 visits a month thereafter.") Both the older version and the current version of this rule also impose a duty upon medical providers to justify frequency of treatment in excess of the limits in the rule. The relevant wording of the rule has changed, but the concept has been constant, i.e., as currently stated in OAR 436-69-201(2)(a): "Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services."

SAIF's response to Dr. Llewellyn's billings during late 1982 and early 1983 consisted of a printed document titled "disputed payment voucher." The front of each of these documents submitted to Dr. Llewellyn (presumably together with SAIF's payment for the undisputed amounts) states:

> "The undisputed portion of your bill has been paid. If you do not agree with the adjustment, please provide us with your justification in writing, and we will either accept your explanation and pay the disputed amount or notify you that we will not pay. You may then refer the matter to the Workers' Compensation Department requesting that they resolve the issue."

A series of 38 "adjustment codes" are listed on the back of the disputed payment voucher form. The first voucher submitted to Dr. Llewellyn, apparently in October of 1982, has code 13 marked. The rest of the disputed payment vouchers appearing in the record have code 14 marked. These two adjustment codes are explained on the voucher form as follows:

> "13. Frequency of treatment must be justified by report 69-201(2)(a)."
>
> "14. Treatment reduced to the usual range of utilization 69-201(2)(a)."

Apparently sometime after March of 1983, SAIF modified its disputed payment voucher form to add the following: "If we do not receive a response from you within 14 days, we will assume you agree with our adjustment, and consider the matter closed."

The dispute in this case centers on the effect to be given these disputed payment vouchers. The testimony from SAIF's claims examiners supports SAIF's position, as stated in its brief, concerning the purpose of these forms. SAIF's brief states:

> "At this stage, the insurer has only inquired into the legitimacy of the excess treatments by requesting the treating chiropractor to send written justification. The insurer has the right to make this inquiry and require justification under OAR 436-69-201(2)(a) . . . This inquiry alone does not affect claimant's right to receive medical treatment."

Claimant argues that, by designating code 14, SAIF intended to

deny payment for more than four treatments per month and that, contrary to SAIF's position and the Referee's conclusion, the chiropractic treatments for which SAIF has refused payment are de facto denied.

The disputed payment vouchers in this record are certainly not models of clarity when considered alone. In view of the narrative statement appearing on the front of the form, it is difficult to understand why either code 13 or code 14 is used. Indeed, the Referee questioned SAIF's senior claims examiner about this, but her responses did not clarify this situation.

We believe it is fairly clear, even without considering the testimony of SAIF's claims examiners, that the principal thrust of the disputed payment vouchers was a solicitation of additional information from Dr. Llewellyn in order to ascertain whether there was justification for the number of treatments being rendered. The narrative statement on the face of the disputed payment voucher offers the possibility that, upon receipt of such an explanation, payment of the disputed amount would be forthcoming. The voucher also states that, in the event SAIF did not deem the physician's explanation satisfactory, the physician would be informed of this fact.

Claimant makes no contention that an insurer does not have the right to request evidence of the efficacy of treatment, as provided by OAR 436-69-201(2)(a), and the Court of Appeals has since upheld the validity of this administrative rule. Kemp v. Workers' Comp. Dept., 65 Or App 659, 661-63 (1983), modified on reconsideration on other grounds, 67 Or App 270 (1984).

We conclude that SAIF's actions in sending "disputed payment vouchers" cannot reasonably be construed as a denial of the unpaid portion of Dr. Llewellyn's billings. The fact that the form accompanying partial payment of Dr. Llewellyn's billings solicits an explanation of treatments in excess of the administrative guidelines indicates that SAIF was in the process of making an inquiry and had not yet made the decision to deny payment, pending receipt of further information from Dr. Llewellyn. The testimony of SAIF's claims examiners supports this conclusion.

Even though we conclude that SAIF was making an inquiry, the question remains whether SAIF satisfied its claim processing obligations under ORS Chapter 656, our decision in Billy J. Eubanks, 35 Van Natta 131 (1983), and our more recent decision (issued subsequent to the Referee's order in this case) in Lloyd C. Dykstra, 36 Van Natta 26 (1984).

In Eubanks we concluded that a request for medical services is a claim, that such a claim can be made by a doctor on a claimant's behalf and that each separate doctor's bill submitted to an insurer is a separate and distinct claim. 35 Van Natta at 132. Concerning an employer/insurer's processing obligations with respect to a claim for rendered medical services, which we understand to be the only issue involved in this case, we stated in Eubanks:

> "The appropriate responses are to either pay the bill or to issue notice of denial or partial denial to the claimant and the

> medical provider. Such a denial should advise the claimant of his or her hearing rights. If the insurer or self-insured employer has previously issued notice of claim acceptance, it need not issue any additional notice of acceptance every time it pays a medical bill." 35 Van Natta at 135.

We also concluded that the statutory response time for all claims for medical services is 60 days.

In Dykstra, SAIF argued that the issue of the frequency of the claimant's chiropractic treatment was a dispute between SAIF and claimant's chiropractor, one in which claimant had no interest; and that exhaustion of the administrative remedies provided by the Workers' Compensation Department rules governing medical services was a jurisdictional prerequisite to a claimant's hearing request pursuant to ORS 656.283. We concluded to the contrary:

> "[T]he Hearings Division and the Board have jurisdiction to consider the issue of frequency and extent of medical treatment being provided to an injured worker, and the claimant may bring such issues before this agency by requesting a hearing pursuant to ORS 656.283. Insurers are obligated to notify the claimant in accordance with our decision in Billy J. Eubanks, supra, when an insurer believes that the frequency and extent of treatment is excessive and, therefore, neither reasonable nor necessary for treatment of a condition resulting from claimant's industrial injury. The insurer's duty to notify claimant, and claimant's physician as well, and the claimant's corresponding right/duty to timely request a hearing contesting the denial exist independently of the insurer's right or the right granted to medical vendors, to invoke the administrative procedures provided by the applicable department rules governing medical services." 36 Van Natta at 39.

Our decisions in Eubanks and Dykstra were premised upon the facts and argument presented in those cases. In both cases the insurer had decided that payment for the medical or chiropractic services in issue would not be made. By contrast, the evidence in this case establishes that, at the time SAIF issued the disputed payment vouchers, no decision had been made about whether to pay for all of claimant's chiropractic treatment; rather, SAIF was merely asking for more information, was indicating that it was willing to consider Dr. Llewellyn's explanation for more than four treatments per month and was "leaving the door open" for the possibility that, based on Dr. Llewellyn's explanation, payment would be forthcoming for all of claimant's treatment.

Despite our conclusion that SAIF's disputed payment vouchers were only in the nature of an inquiry, and not in the nature of a

denial, it is nevertheless possible for a claim for medical services to be denied de facto. This is illustrated by Kevin Bethel, 36 Van Natta 1060 (1984). In that case, in response to a chiropractor's bills for treatment in excess of the guideline in the Department's rules, SAIF issued the same kind of disputed payment vouchers involved in this case. In Bethel, the chiropractor responded with narrative reports that stated his reasons for believing that additional treatment was necessary. SAIF took no further action after receipt of these reports. We concluded that, after receipt of these reports,

> ". . .it was then incumbent upon SAIF to do something more, i.e., either accept the doctor's justification for the frequency of his treatment and thus to pay his bills in full, or to reject the doctor's justification for the frequency of his treatment and thus to deny the unpaid portion of his bills. [Citation omitted.] It was only when SAIF failed to react in any way to [the doctor's] submission of the information it requested that the pending claim in the form of partially unpaid bills could be said to be in de facto denied status, and when this Board's jurisdiction under Dykstra could come into play." 36 Van Natta at 1061.

There is a significant difference between the facts in Bethel and the facts in this case. Here the record contains no trace of any communication from Dr. Llewellyn to SAIF, in response to the request for additional information on the disputed payment vouchers, which could reasonably be construed as an effort on the doctor's part to explain why this claimant was in need of the number of treatments being provided. In other words, the present situation is: (1) a bill, i.e., claim, from a medical provider to an industrial insurer; (2) followed by the insurer requesting additional information from the medical provider; (3) followed by no response from the medical provider. Also, during all of this exchange between the doctor and the insurer, claimant was receiving all medical services that his treating chiropractor felt it was appropriate to render. Should the concept of de facto denial of a claim be extended to this situation so that, after the passage of 60 days from the medical provider's bill, a claimant has the right to request a hearing protesting a de facto denial?

We think not. In considering the validity of that portion of OAR 436-69-201(2) which allows an insurer to request information from a medical provider about the treatment being rendered, the court stated in Kemp, supra:

> "We agree . . . that the rule does not limit treatment but merely requires that, if the treatment exceeds the prescribed number of visits the physician must submit a report justifying further treatment. That is consistent with the legislative policy of requiring medical service to be provided only for the period of time necessary for recovery." 65 Or App at 663 (emphasis added).

This Board has no regulatory authority by which we are able to require physicians to respond to reasonable inquiries from insurers. Our authority and jurisdiction are limited to hearing contested cases in which there is an issue concerning a claimant's entitlement to receive compensation or the amount thereof. ORS 656.704(3); SAIF v. Broadway Cab, 52 Or App 689 (1981). There is a potential issue in this case concerning a claim within the meaning of ORS 656.704(3). Lloyd C. Dykstra, supra. Whether there presently is an issue which is ripe for adjudication, however, is another matter. See Thomas v. SAIF, 64 Or App 193 (1983); Syphers v. K-W Logging, Inc., 51 Or App 769 (1981). To give meaningful effect to the duty of medical providers to respond to insurers' requests for information, stated in OAR 436-69-201 and recognized in Kemp, we conclude it is appropriate to find the present "dispute" not yet ripe for adjudication because of Dr. Llewellyn's failure to respond to SAIF's inquiries.

Furthermore, and as a distinct consideration from this indirect enforcement of the physician reporting duty, there remains the possibility that no hearing will ever be necessary. An industrial insurer has requested information that it deems, and reasonably so, to be needed in connection with its ongoing processing of an accepted injury claim. When that information is provided, the insurer might find that information sufficient reason to pay for all benefits in issue. It would squander finite hearing resources and generate unwarranted litigation costs to proceed with a hearing before it is really known whether a hearing is necessary.

In so concluding, we are assuming that some additional delay to provide Dr. Llewellyn additional time to respond to SAIF's inquiries creates no hardship for claimant because he is continuing to receive the medical services in question. A different result might be indicated if there was any suggestion of real hardship for a claimant. On the other hand, however, a claimant has the right to select his treating physician and we assume that, with this right, goes the right to urge that the selected physician cooperate with the physician reporting duties that are associated with medical treatment of injured workers. Stated differently, it would seem appropriate for a claimant facing potential hardship in this kind of situation to request cooperation from his doctor before requesting a hearing.

For all of these reasons, we conclude that SAIF had no obligation to further process the unpaid portions of Dr. Llewellyn's bills pending receipt of some statement from him in at least substantial compliance with the requirements of OAR 436-69-201(2)(a), and that there is no de facto denial of the chiropractic services in issue pending receipt of such a response. It necessarily follows that claimant's hearing request was premature.

With respect to the second issue of claimant's alleged preference for a TNS unit provided by Dr. Llewellyn, we affirm and adopt the relevant portions of the Referee's order.

ORDER

The Referee's order dated July 6, 1983 is modified in part to

provide that the portion of claimant's hearing request raising an issue concerning the extent and frequency of his chiropractic treatment is dismissed as premature. As so modified, the Referee's order is affirmed.

RUTH A. CODDINGTON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05848
August 14, 1984
Order on Remand

On review of the Board's order dated June 10, 1983 the Court of Appeals reversed the Board's order and remanded with instructions to reinstate the order of the Referee dated August 10, 1982.

Now, therefore, the above-referenced Board order is vacated, and the above-referenced Referee's order is republished and affirmed.

IT IS SO ORDERED.

FRANK A. HAMEL, Claimant
Francesconi & Cash, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-07333
August 14, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order which awarded claimant 64° for 20% unscheduled disability in addition to the 16° for 5% unscheduled disability previously awarded. The self-insured employer cross-requests review alleging that the Referee's award is excessive. Extent of disability is the issue on review.

Claimant is a 41 year old bus driver who injured his low back on November 21, 1978. The claim was denied by the employer, but ultimately was found compensable by the Court of Appeals. On July 7, 1980 claimant alleged another on-the-job injury which was accepted by the employer. February 25, 1982, following the Court of Appeals' decision, the two claims were merged by stipulation. The second injury was thenceforth considered an aggravation of the first injury. A February 5, 1982 Determination Order which awarded 16° for 5% unscheduled disability was unchallenged.

The claim was reopened as an aggravation in November 1982 when claimant submitted to a second laminectomy. It was closed by a Determination Order dated June 2, 1983 which granted no additional award for permanent disability. Claimant requested a hearing to protest that Determination Order.

In order to be entitled to a redetermination of permanent disability following an aggravation, claimant must show a change in circumstances since the last arrangement of compensation. James B. Johnson, 35 Van Natta 47 (1983). However, upon a showing of changed circumstances, claimant is entitled to have his permanent disability redetermined as of the time of the hearing. See Eduardo Ybarra, 36 Van Natta 1108 (1984).

With that understanding, we consider the extent of claimant's disability as of the date of the hearing. On de novo review, we conclude that the Referee's award was excessive. Claimant is a 41 year old bus driver who has returned to his job. He has two years of college education. He has had four surgeries, but according to his treating physician is only limited to medium work. Claimant has some disabling pain which we consider in rating his disability. After considering the guidelines contained in OAR 436-65-600 et seq., and comparing this case with other like cases, we conclude that claimant would be adequately compensated by an award of 32° for 10% unscheduled disability in addition to the 16° for 5% unscheduled disability previously awarded.

ORDER

The Referee's order dated February 3, 1984 is modified. Claimant is awarded 32° for 10% unscheduled disability in lieu of the 64° for 20% unscheduled disability awarded by the Referee. Attorney's fees shall be adjusted accordingly.

THOMAS E. MEANS, Claimant
Flinn, et al., Claimant's Attorneys
Goff & Smith, Attorneys
SAIF Corp Legal, Defense Attorney
Carl Davis, Asst. Attorney General

WCB 81-09925 & 81-09924
August 14, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Diamond C Construction requests review of that portion of Referee Shebley's order which could be interpreted to require Diamond to reimburse the SAIF Corporation for the benefits SAIF has paid and will pay to claimant in connection with this claim.

Diamond C Construction is a noncomplying employer. Claimant was injured while working for Diamond, in the course of Diamond's performance of a construction contract for Arcuri Stables. Arcuri Stables is insured by SAIF. The Referee found that, under these circumstances, claimant was deemed to be an employe of Arcuri Stables by operation of ORS 656.029 and ordered SAIF to accept and process claimant's claim in its role as Arcuri's insurer. SAIF argues that the Referee misinterpreted and misapplied ORS 656.029 in so concluding. In what may have only been dicta, the Referee also made statements to the effect that Diamond C Construction should reimburse SAIF for the cost of this claim; as previously indicated, Diamond challenges this portion of the Referee's order.

SAIF's arguments in this case concerning interpretation and application of ORS 656.029(1) are indistinguishable from similar arguments we considered and resolved adversely to SAIF's positon in Richard O. Hampton, 36 Van Natta 230 (1984). We thus agree with the Referee's conclusion that SAIF, as insurer for Arcuri Stables, must bear the responsibility for this claim.

Regarding Diamond's arguments about whether it should be required to reimburse SAIF for the costs of this claim, we note that it is not clear that the Referee actually ordered any reimbursement. If he did so or intended to do so, such an order would be erroneous. When ORS 656.029 is applicable, as we have found it to be in this case, the effect of that statute is to "deem" that somebody (here claimant) is an employe of somebody else (here Arcuri Stables) by operation of law. Just as the insurer for an actual employer would have no possible claim for

reimbursement from any source if one of the actual employer's actual employes were injured, the insurer for a "deemed" employer has no possible claim for reimbursement if a "deemed" employe of the "deemed" employer is injured; instead, so far as our jurisdiction is concerned, SAIF in its role as Arcuri's insurer must assume the cost of claims by Arcuri's "deemed" employes just as it assumes the cost of claims by Arcuri's actual employes. As we noted in Hampton, there may be remedies available to SAIF elsewhere that might have the effect of shifting the costs of a claim like this one to the noncomplying employer, but that "question will ultimately be determined in some forum other than this agency." 36 Van Natta at 233.

ORDER

The Referee's order dated June 25, 1982 is clarified and modified as follows. The denial issued by the SAIF Corporation as processing agent for Diamond C Construction, a noncomplying employer, is affirmed. All references to any possible right of reimbursement for claim costs as between SAIF and Diamond C Construction are vacated. As so clarified, the Referee's order is affirmed.

RONALD A. PICKETT, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03535 & 84-05660
August 14, 1984
Order of Dismissal of Cross-Request for Review

Claimant has filed a cross-request for review of the Referee's order dated July 3, 1984. The 30 days for filing the cross-request expired August 2, 1984. The cross-request was dated August 3, 1984 and was received by the Board August 3, 1984. Therefore, the cross-request for review is dismissed as being untimely filed.

IT IS SO ORDERED.

RICHARD L. TOMMILA, Claimant
David Force, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-11237
August 14, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Quillinan's order which found that the insurer was not responsible for chiropractic treatments in excess of four per month and assessed the insurer a 10% penalty and accompanying attorney fees for its failure to deny medical bills within 60 days. On review, claimant contends all of his chiropractic treatments are compensable and that the penalty should be increased. The insurer argues no penalty is warranted because there is no amount "then due" upon which to base the penalty.

The Board affirms that portion of the Referee's order pertaining to the insurer's responsibility for the chiropractic treatments.

That portion of the order which assessed a penalty is reversed.

Claimant received chiropractic treatments from his treating physician, Dr. Cohen, approximately three times a week. The insurer did not formally accept or deny the bills it received from Dr. Cohen for his services. Instead the insurer paid for four treatments per month and subsequently referred the "treatment" issue to the Medical Director.

The Referee found, and we agree, that the insurer was not responsible for chiropractic treatments in excess of four treatments per month, such treatments being neither reasonable nor necessary.

When there is a claim for rendered medical services in the form of a bill, within 60 days, the insurer must either pay the bill or issue a denial with notice of appeal. Billy J. Eubanks, 35 Van Natta 131 (1983). Penalties for such unreasonable conduct are computed on compensation "then due." ORS 656.262(10); Richard Kirkwood, 35 Van Natta 140, 142 (1983).

Since the insurer paid for that portion of the chiropractic treatments we find compensable, it follows that no compensation "then due" exists upon which to base a penalty. Accordingly, no penalty shall be imposed.

ORDER

The Referee's order dated November 16, 1983 is affirmed in part and reversed in part. That portion which assessed the insurer a penalty and associated attorney fees for failing to deny medical bills within 60 days is reversed. The remaining portion of the Referee's order presented to the Board for review is affirmed.

RUFUS G. WHITAKER, Claimant
Myrick, et al., Claimant's Attorneys
John Snarskis, Defense Attorney

WCB 83-02976
August 14, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Brown's order which denied claimant's request for temporary disability from April 26, 1982 through September 29, 1982. Claimant contends that he is entitled to temporary disability for that period, although the insurer is entitled to offset the amount of any unemployment benefits received by claimant during that period. The Board agrees with claimant and reverses.

We make the following findings of fact. Claimant injured his low back in March 1982 and was treated by Dr. Gentry. Claimant returned to light duty at first, but when told by his supervisor that he needed a full release or he would be laid off, claimant obtained from Dr. Gentry a full release to return to work on April 26, 1982. Claimant was laid off after working 4 hours on April 26. Claimant thereafter received umemployment benefits.

Claimant's claim initially was denied, but was found compensable in January 1983. After being ordered to accept the claim, the insurer paid claimant temporary disability benefits, including benefits for the period April 26, 1982 through September 29, 1982.

Later, the insurer notified claimant that he was not entitled to benefits for this period and that it would be recovering this overpayment from claimant's ongoing temporary disability benefits.

In the meantime, claimant returned to Dr. Gentry in September 1982 with complaints of continuing low back pain and leg numbness. Dr. Gentry referred claimant to Dr. Strukel, orthopedist, who diagnosed a herniated disc and authorized time loss as of his first visit on September 30, 1982. Dr. Strukel eventually performed a laminectomy and discectomy. In April 1983 Dr. Strukel reported that he had reviewed claimant's records, that he expected that claimant had had some worsening after returning to work on April 26, 1982, and that claimant could not have worked from April 26, 1982 through September 30, 1982. The record contains no contrary medical evidence.

We find that claimant was not medically stationary and not able to work his regular job on April 26, 1982, in spite of Dr. Gentry's release to return to full duties. We rely on Dr. Strukel's opinion that claimant was not able to work from April 26 through September 29, 1982. See Daniel Leaton, 36 Van Natta 1081 (1984). Therefore, claimant is entitled to temporary disability for that period. Moreover, the insurer is entitled to deduct from the temporary disability owed for that period any unemployment benefits received by claimant during that period. Daniel Cannon, 35 Van Natta 1181 (1983).

ORDER

The Referee's order dated October 5, 1983 is reversed. Claimant is awarded temporary disability benefits from April 26, 1982 through September 29, 1982. Claimant's attorney is awarded 25% of the temporary disability awarded as an attorney fee, to be paid out of claimant's compensation. The insurer is entitled to deduct from the temporary disability owed the amount of any unemployment benefits received by claimant during said period.

HUBERT W. BARKER, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06049
August 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Mongrain's order which held: (1) that he did not have jurisdiction to order the SAIF Corporation to reopen the claim as of October 3, 1982; (2) that he did not have jurisdiction to order SAIF to reimburse claimant for amounts erroneously deducted from temporary total disability; and (3) that claimant's attorney was entitled to an attorney's fee of $100 for prevailing on the issues of late reimbursement for travel expenses and for eyeglasses. SAIF cross-requests review of those portions of the Referee's order which allowed claimant to preserve the issue of the extent of his disability for a later date.

FACTS

On September 16, 1974 a steer dragged claimant into a fence and across the ground thus injuring his back and neck. The first

award or arrangement of compensation was a Determination Order dated October 27, 1976. Therefore, claimant had a right to reopening due to an aggravation for five years, that is until October 27, 1981. On October 27, 1981, the claim was in open status due to an aggravation. A Determination Order issued on June 7, 1982. Claimant timely requested a hearing to protest the June 1982 Determination Order. On November 11, 1982 SAIF voluntarily reopened the claim and began paying time loss. SAIF began deducting a portion of the time loss benefits to offset an earlier overpayment. The parties later discovered that SAIF had miscalculated the amount of the overpayment and that it had deducted more from claimant's time loss benefits than he had been overpaid.

In March 1983 the parties signed a stipulation which in pertinent part stated: (1) that the claim should have been reopened on October 3, 1982 rather than November 11, 1982; (2) that SAIF had miscalculated the overpayment, had recovered all but $5 of the overpayment and would not offset any further time loss benefits; (3) that the June 1982 Determination Order would stand; and (4) that claimant waived any penalty. The stipulation was never approved by a Referee or the Workers' Compensation Board. The Referee concluded that the stipulation was not enforceable. We agree.

At the time of hearing, claimant contended that SAIF had continued to take an offset from claimant's time loss benefits. SAIF conceded that through error it had continued to take the offset. Claimant sought reimbursement for the amount erroneously deducted from his time loss benefits. Claimant sought a penalty and associated attorney's fee for the erroneous deductions. In addition, claimant sought a penalty and attorney's fee for SAIF's late reimbursements for mileage and eyeglasses. Finally, claimant sought to have the issue of the extent of his disability preserved because the claim was in open status at the time of hearing. SAIF contended that the reopening was an "own motion" reopening so the Referee was without jurisdiction over the reopening or any issues associated with it.

The Referee concluded that he was without jurisdiction to order the claim reopened on October 3, 1982 rather than November 11, 1982. He stated that because he had no jurisdiction over the reopening, he was without jurisdiction to consider the issue of the erroneous deduction or penalties and fees due to the erroneous deductions. The Referee allowed claimant to raise the issue of extent of disability at a later date.

OPINION

The Board affirms the Referee on the issue of the attorney's fee because the $100 fee is commensurate with the services rendered. We also affirm the Referee on the issue of reserving the question of extent of disability. The claim was in an open status at the time of hearing so it would have been improper to rate extent. Gary A. Freier, 34 Van Natta 543 (1982).

On the issue of whether the Referee had jurisdiction over the November 1982 reopening we hold that he did. At the time claimant's aggravation rights expired his claim was in open status. The claim was closed by a Determination Order and SAIF voluntarily reopened the claim within one year of the Determination Order. Such a reopening entitles claimant to claim

closure pursuant to ORS 656.268 with attendant rights of appeal. Coombs v. SAIF, 39 Or App 293 (1979); Carter v. SAIF, 52 Or App 1027 (1981). Accordingly, claimant will be entitled to a Determination Order when he becomes stationary.

When SAIF voluntarily reopened the claim, it picked the wrong date for beginning time loss payments. It should have begun them on October 3, 1982 when the evidence establishes that claimant's condition had aggravated rather than November 11, 1982. Accordingly, we find that claimant is now entitled to time loss payments from October 3, 1982.

The parties agree that SAIF erroneously deducted sums from claimant's time loss benefits. SAIF shall reimburse claimant for all amounts erroneously deducted from his time loss benefits.

SAIF was admittedly aware that it had miscalculated the amount it had overpaid claimant. However, due to some mistake it continued to deduct sums from claimant's time loss checks. We do not believe that mistake is sufficient excuse for continuing to deduct money from time loss benefits when SAIF knew it had already recouped its overpayment. We assess a penalty of 25% of that amount for unreasonable resistance to the payment of compensation. Claimant's attorney is awarded an associated attorney's fee of $300, to be paid by SAIF.

ORDER

The Referee's orders dated October 27, 1983 and December 6, 1983 are affirmed in part and reversed in part. Those portions of the Referee's order finding no jurisdiction over the voluntary reopening and associated issues are reversed. SAIF is ordered to pay claimant time loss benefits beginning October 3, 1982. SAIF is ordered to reimburse claimant for all sums erroneously deducted from his time loss payments. In addition SAIF shall pay a penalty of 25% of the amounts due plus an associated attorney's fee of $300. The balance of the Referee's order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

HELEN D. OLVERA, Claimant
Velure & Bruce, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-00950
August 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Mongrain's order which upheld the SAIF Corporation's denial of "dorsal spinal arthritis, osteoarthritis, degenerative disc disease and cervical spondylosis," which the Referee construed as a denial of claimant's neck/upper back condition only. Claimant contends that the Referee erroneously interpreted SAIF's denial in that it was intended as a denial of her cervical/dorsal spinal condition (i.e., neck/upper back) and her low back condition. Claimant further contends that the present condition of her neck/upper back and low back is causally related to her April 28, 1975 industrial injury; and that the Referee erred in concluding that SAIF is not subject to penalties and attorney fees for its allegedly unreasonable denial. SAIF seeks an order affirming the Referee's order.

We agree with claimant that SAIF intended to place in issue the compensability of her present low back condition, and not merely the compensability of the condition of her cervical/dorsal spine. SAIF's denial states in pertinent part:

> "Since your claim was closed you have been under care for dorsal spinal arthritis, osteoarthritis, degenerative disc disease and cervical spondylosis. The SAIF Corporation finds that these conditions did not arise out of your April 28, 1975 injury or its treatment. Therefore, we are denying responsibility for treatment of these conditions . . . .
>
> "This denial does not interfere with your right to treatment for any sequelae of your compensable injury which required surgery on October 21, 1975, if such need should ever arise."

When the hearing convened, a considerable amount of time was spent discussing the scope of the denial vis-a-vis the different portions of claimant's spine. The following colloquy is reported:

> "Referee: Did you say that Denial of January 14, 1982 intended, as far as you can tell, to raise the question of SAIF Corporation responsibility for treatment as of that time to the claimant's low back?
>
> "Mr. Owen [SAIF's attorney]: Yes, I would say that it does, insofar as the degenerative disc process or the degenerative disease became the predominant reason for treatment rather than the compensable injury in this particular case.
>
> "Referee: But didn't Mr. Johnson's Opinion and Order of December 1976 in effect hold SAIF Corporation responsible for degenerative disc disease; isn't that the essence of his opinion?
>
> "Mr. Owen: I see that it's mentioned. I would raise the question of whether or not the degenerative disease in that Opinion and Order is the same as the one the claimant was seeking treatment for in 1982. Therein would lie the difference. And, of course, our denial is based upon Dr. Reilly's medical opinion . . . .
>
> " * * *
>
> "Mr. Owen: I do want to say in the next breath that I am not denying our responsibility under the original injury."

Thus, what was arguably vague and ambiguous under the terms

of SAIF's written denial became very clear at hearing, with the benefit of counsel's statements. SAIF, in fact, did intend to deny the current condition of claimant's low back. SAIF's brief on review asserts that the Referee correctly determined the scope of its denial, and in response to claimant's assignment of error, states:

> "Appellant does not base this argument on the wording of the denial itself. Rather, appellant argues that the wording of neurologist Philip J. Reilly's opinion establishes the true nature of SAIF's subsequent denial. Certainly SAIF is not bound by the opinion of a consulting physician. While the first paragraph of the January 14, 1982 denial may be broad, the second paragraph is clear that SAIF continued to accept responsibility for claimant's low back condition. It is irrelevant whether Dr. Reilly felt this previously accepted responsibility [i.e. accepted through litigation] was appropriate or not. The January 1982 denial specifically accepted responsibility for the low back and Referee Mongrain confirmed this acceptance. The issue is moot."

Although SAIF certainly is not bound by the opinion of a consulting physician, we believe that, in defining the scope of issues to be resolved at hearing, SAIF is bound by the statements of its counsel. Based upon the above-quoted colloquy at the time of hearing, it is clear that SAIF's denial included a denial of claimant's current low back condition. For this reason, SAIF's argument on review, which is in marked contrast to the position taken at hearing, is not persuasive.

To the extent that SAIF's denial was intended to place in issue the causal relationship between claimant's 1975 injury and her current low back condition, it is necessary to set aside that denial in part and award a reasonable attorney's fee. Although SAIF has not pursued its compensability argument on review with regard to the condition of claimant's low back (and indeed now admits compensability), we deem it appropriate to award a modest attorney's fee on Board review since it has been necessary for claimant to bring this case before us in order to correct the Referee's error concerning the scope of SAIF's denial.

With regard to the compensability of the current condition of claimant's cervical/dorsal spine, we affirm the Referee's order. Claimant maintains that SAIF's refusal to pay medical expenses in connection with treatment for claimant's current neck/upper back condition cannot be sustained in light of Bauman v. SAIF, 295 Or 788 (1983), and its progeny. We recently have held that Bauman does not preclude partial denials for continuing medical services which the insurer believes are not causally related to the original accepted claim. Clyde C. Wyant, 36 Van Natta 1067 (1984). See also John E. Russell, 36 Van Natta 678 (1984) (expressing "serious doubts" concerning whether the Bauman doctrine can or should be applied to partial denials); Roller v.

Weyerhaeuser Co., 67 Or App 583, 586-87, adhered to on reconsideration 68 Or App 743 (1984) (distinguishing the employer's denial from the denial in Bauman, and suggesting that Bauman does not affect the employer/insurer's "post-closure right to deny claims for specific medical treatments or for aggravation on the ground that they do not 'result from the injury'"). Accordingly, SAIF's denial of medical treatment for claimant's current cervical/dorsal condition was procedurally permissible. On the merits, we agree with the Referee's determination that a preponderance of the evidence fails to establish a materially causal relationship between the presently severe degenerative condition of claimant's cervical spine and her 1975 industrial injury.

On the issue of penalties and attorney fees, we affirm the Referee's order, albeit for slightly different reasons. A trier of fact might conclude that SAIF's denial of continuing responsibility for the condition of claimant's low back was unreasonable, in view of the circumstances existing at the time of the 1976 litigation order directing acceptance of claimant's low back condition and payment of compensation in connection therewith, including surgery for a laminectomy and fusion, as well as the circumstances existing at the time of a March 10, 1980 stipulation, by the terms of which claimant's permanent disability award was increased to "80 percent low back disability"; however, we need not make that finding. Assuming arguendo that the denial of claimant's low back condition was unreasonable, there is no evidence of any unpaid medical bills for treatment of claimant's low back. There is, therefore, no evidence of any "amounts then due" to form the basis for imposition of a penalty. Neither a penalty nor an associated attorney's fee may be imposed under these circumstances. Ray A. Whitman, 36 Van Natta 160 (1984); Darrell W. Carr, 36 Van Natta 16 (1984); EBI Companies v. Thomas, 66 Or App 105 (1983).

ORDER

The Referee's order dated December 13, 1983 is modified in part. The SAIF Corporation's denial dated January 14, 1982 is partially set aside, insofar as it denies SAIF's continuing responsibility for payment of compensation in connection with the condition of claimant's low back. Except as so modified, the Referee's order is affirmed. Claimant's attorney is awarded $650 for services at hearing and $250 for services on Board review, for partially prevailing on SAIF's denial. Attorney fees payable under the terms of this order are to be paid by the SAIF Corporation in addition to and not out of any compensation to which claimant is entitled.

THOMAS E. SELLMAN, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10942
August 15, 1984
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Seifert's order which reversed SAIF's denial of claimant's aggravation claim and awarded claimant's attorney $100 for SAIF's late denial of the claim. SAIF contends that claimant's aggravation claim is not compensable and that the Referee should not have penalized SAIF for its actions with regard to the late denial.

The Board affirms the order of the Referee insofar as it found claimant's aggravation claim compensable but reverses the award of $100 attorney fee associated with SAIF's late denial.

The Referee did not award a penalty for SAIF's late denial apparently because no medical verification of claimant's inability to work triggered SAIF's duty to pay temporary total disability, upon which penalties are to be assessed. The Referee found penalties to be appropriate but only awarded the associated attorney fee. Since the Referee's order, the Board decided Darrel W. Carr, 36 Van Natta 161 (1984), in which we held that if no penalty is appropriate because no amounts are "then due," then no associated attorney fee is appropriate. We find that case to be applicable to this case and accordingly, we reverse the Referee's award of $100 attorney fee associated with SAIF's late denial.

ORDER

The Referee's order dated October 5, 1983 is affirmed in part and reversed in part. The Referee's order of $100 attorney fee for SAIF's late denial is reversed and the remainder of the order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

BOARD MEMBER BARNES DISSENTING:

I disagree with that portion of the Board's order which finds that claimant has established a compensable aggravation claim.

The real problem in this case, which was not really discussed by the Referee and is not even mentioned by the Board majority, is: What is the causal link, if any, between a 1980 injury in one body area and 1982 symptoms in another body area?

Claimant sustained a compensable injury in July 1980 that the contemporaneous reports discuss primarily as an arm/shoulder injury, although there is also some fleeting mention of neck pain. Claimant's 1982 symptoms that are the basis of this aggravation claim are primarily neck symptoms, although there is also some fleeting mention of increased arm/shoulder pain.

Where is the evidence that the 1980 arm/shoulder injury caused the 1982 neck symptoms? The Referee has not identified it. The Board majority has not identified it. I cannot find it. Indeed, I submit that the evidence is clearly to the contrary. Dr. Woolpert, who has been claimant's primary treating physician since the 1980 injury, testified at deposition:

> "Q: Absent a history of a specific trauma . . . to the neck on July 29, 1980, is there any reason particularly to implicate that specific work incident on that date to an acceleration of the progression of this disease? As opposed -- I am severing out now the occupational disease component about repetitive stress; that particular single incident or single day at work?
>
> "A: I don't really think so. Because [claimant] was actually complaining about

the neck pain and also the left shoulder prior to that, so he had these complaints prior to that episode.

"Q: As an industrial injury, as opposed to occupational disease then, just to make it clear on the record, there is no reason to implicate that particular incident as being a causative factor of his current cervical problems?

"A: No, I don't think so." (Emphasis added.)

On a record that is this adverse to the result the Board majority wants to reach, it is easy to understand why the majority puts out an order that merely states a conclusion without even a pretense of supporting analysis and reasoning.

I would reverse that portion of the Referee's order that set aside SAIF's denial of claimant's aggravation claim and, therefore, respectfully dissent.

LELAND M. SPORE, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03426
August 15, 1984
Order on Remand

This case is before us again on remand from the Court of Appeals for reconsideration.

The court's order notes that our prior decision, 36 Van Natta 153 (1984), relies upon a report that the Referee refused to admit into evidence. Having reviewed the record again, that criticism is correct.

Dr. Holland submitted a report which appears in the record as Exhibit 18, but which the Referee excluded from evidence. Our prior Order on Review quoted from Dr. Holland's report, 36 Van Natta at 155-56.

Although this reliance on a report not in evidence was error, we suggest that it was something akin to harmless error. Dr. Holland also testified at the hearing, and our prior Order on Review also relied upon the doctor's testimony, 36 Van Natta at 156-57. On reconsideration, we find no material differences between the substance of Dr. Holland's written report (which was not admitted into evidence) and the substance of Dr. Holland's hearing testimony (which, of course, was admitted into evidence). Dr. Holland's report is more quotable because the written word is often clearer than a transcription of the spoken word; but, aside from such inevitable nuances, we find that all of the same concepts, opinions and explanations are expressed in Dr. Holland's hearing testimony. Accordingly, we will amend our prior Order on Review to eliminate any reference to Dr. Holland's written report and instead rely only on Dr. Holland's hearing testimony as our support for our findings, analysis and conclusions which remain the same.

ORDER

On remand and reconsideration, the Board's Order on Review dated February 15, 1984 is readopted and republished effective this date with the exception that all references to Dr. Holland's findings and opinions as expressed in Exhibit 18 are eliminated.

JOE W. TEMPLETON, Claimant
David Force, Claimant's Attorney
Coons & McKeown, Attorneys
Roberts, et al., Defense Attorneys

WCB 82-08021, 82-09206 & 82-09207
August 15, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Quillinan's order which: (1) set aside the insurer's September 29, 1982 denial insofar as it denies that claimant's June 3, 1981 compensable injury was an aggravation of claimant's prior August 8, 1979 and July 28, 1980 compensable injuries with the same employer; (2) remanded the 1979 and 1980 industrial injury claims for payment of benefits and processing to closure pursuant to ORS 656.268; (3) modified the June 14, 1982 Determination Order by awarding claimant additional temporary total disability from February 5, 1982 to August 8, 1982, and by awarding claimant 20% for 38.4° scheduled permanent partial disability for his left arm (elbow) condition (the Determination Order had awarded no permanent disability benefits); and (4) upheld a prehearing order by Referee Mannix and an Interim Order by Referee Quillinan requiring the insurer to pay temporary disability benefits to claimant until the date of Dr. Wright's telephone deposition, but requiring claimant to pay for that deposition.

The insurer contends: (1) that the Referee improperly remanded claimant's 1979 and 1980 elbow injury claims for processing; (2) that the June 14, 1982 Determination Order properly terminated claimant's temporary disability benefits on February 5, 1982; (3) that claimant has incurred no permanent disability to his left elbow as a result of his compensable injuries; and (4) that it was inappropriate that the insurer be ordered to pay temporary disability benefits pending the deposition of Dr. Wright and, furthermore, that Dr. Wright's deposition should be excluded from the record.

In 1977 claimant was in a motorcycle accident which resulted in a serious injury to his left elbow. As a result, he underwent surgical repair by Dr. Vigeland, orthopedic surgeon, which involved the placement of four pins and required 62 days of traction. Claimant had residuals of mild tenderness and weakness in his elbow, but was able to return to moderate to heavy work in a transmission repair shop. He occasionally had some flare-ups of pain which were not disabling to him. In 1977 one of the pins was removed.

By August 8, 1979 claimant was working for the employer. He jammed his left elbow at work, fracturing the radial head. This injury was accepted and required the surgical removal of two more pins. However, he was able to return to his regular work on August 22, 1979. He experienced some loss of grip strength, with an increase in pain. On November 5, 1979 a Determination Order

issued awarding temporary disability benefits, but no permanent disability benefits. By February 1980 claimant's elbow showed signs of ulnar neuritis resulting in weakness of the fourth and fifth fingers of his left hand.

On July 28, 1980 claimant suffered his second injury with the employer lifting a heavy pane of glass. This injury required surgical removal of the remaining pin, plus removal of scar tissue surrounding the ulnar nerve. On September 8, 1980 the doctor's chart note showed that claimant's ulnar neuritis was gone. On September 11, 1980 claimant returned to his regular work. On October 22, 1980 a Determination Order issued for this most recent injury awarding temporary disability benefits, but again awarding no permanent disability benefits.

Then, on June 3, 1981, claimant suffered a third injury while working for the employer. He was "ripping fin" which is an activity requiring rapid, repetitive pushing and pulling of the arms. At this time, claimant experienced a sudden sharp pain in his elbow and paresthesia in his fourth and fifth fingers.

Claimant had been treated by Dr. Wright, orthopedic surgeon, since August 1980, but in June 1981 he returned again to Dr. Vigeland. In November 1981 Dr. Vigeland performed an ulnar nerve transplant in his left arm in an effort to free claimant's entrapped nerve.

On February 5, 1982 Dr. Vigeland found claimant stationary with an ability to return to his regular work. At that time Dr. Vigeland had the opinion that claimant's permanent impairment had not changed, and that he would be able to return to his same job. He suggested that an independent closing examination would be appropriate.

Claimant was then sent back to Dr. Wright for a closing examination on April 9, 1982. Dr. Wright reported that claimant felt that the operation performed by Dr. Vigeland was not helpful, that repetitive movement of the elbow caused pain posteromedially without significant radiation, that he had loss of grip and reduced sensation in the fourth and fifth fingers of his left hand, particularly since the 1980 operation, that he got occasional sharp shooting pain in his left arm which awakened him at night, and that he had numbness present at all times which was worse in the morning. Physical examination revealed range of motion of the elbow from 20° to 150°. Claimant had a well-healed scar on the medial side of his elbow that was not sensitive to touch. There was an older scar posteriorly. Pronation and supination were full. His grip strength was one-quarter of that of his right arm. He did not have two point discrimination on the ulnar side of his hand up to the middle of the middle finger. Claimant was, however, able to distinguish pinprick. He was very tender over the area of the ulnar nerve. There were no definite signs of medial epicondylitis or weakness of those muscles enervated by the ulnar nerve. An x-ray showed no change from that done the previous year.

Dr. Wright's impression was that, being only five months since the ulnar nerve transposition, it was too early to say that claimant was medically stationary. He estimated it could take up to 18 months more for the final signs of improvement to occur from

that surgery. His findings demonstrated chronic irritation of the ulnar nerve, although actual examination of the muscles enervated by the ulnar nerve did not substantiate that finding. The doctor felt that claimant's work injuries did aggravate his preexisting elbow condition. He stressed that claimant was unable to return to his job with the employer and thought he would reinjure himself if he did so since the job involved heavy lifting of a repetitive nature.

On May 28, 1982 Dr. Vigeland responded to Dr. Wright's report. He agreed with Dr. Wright's findings, but felt that the grip strength test was very unreliable in claimant's case because, in his opinion, his subjective complaints far outweighed the objective abnormalities. Further, although he agreed that claimant suffered permanent loss of function in his left arm and that he was unable to return to his job with the employer, it was his opinion that it was entirely the result of the motorcycle accident.

Another Determination Order issued on June 14, 1982 again awarding only time loss. On September 24, 1982 claimant filed an aggravation claim based on Dr. Wright's April 9, 1982 report. This was denied by the insurer on September 29, 1982.

Dr. Wright was then deposed on December 13, 1982. At that time Dr. Wright indicated he had seen claimant once more on October 8, 1982 and had found claimant medically stationary from his surgery. Dr. Wright described claimant's disability as being moderate in that he was restricted to light work. Claimant's left arm impairment was due to poor function of the nerves causing pain with reduced sensation and reduced grip. Dr. Wright stated that although claimant's grip would vary from one-quarter to one-half of that of the right side, he did not find that variance unusual in a case where the reduced grip strength is due to pain. Grip strength can vary depending on how relaxed the arm is. Dr. Wright stated that he had tested claimant in the past and "had never managed to catch him out or anything," and, therefore, that claimant had a definite reduced feeling in the skin and enervation by the ulnar nerve. The doctor attributes claimant's present condition to the succession of injuries. Although he recognized that claimant sustained significant injuries due to the original 1977 motorcycle accident, he felt the work injuries also contributed to that condition as they occurred on top of an already weakened elbow. Dr. Wright concluded that the distribution of complaints that claimant had regarding his left elbow were consistent with the ulnar neuropathy for which Dr. Vigeland performed the ulnar transposition.

All three of claimant's on-the-job injuries were treated as separate injuries and were assigned separate claim numbers. Upon review of the evidence, the Referee determined that the 1981 injury was actually an aggravation of the 1979 and 1980 injuries. The Referee then remanded the 1979 and 1980 claims to the insurer for processing. Then, upon finding that claimant was entitled to greater benefits than that awarded by the June 14, 1982 Determination Order, the Referee also determined the amount of claimant's temporary and permanent disability. Although it is easy to see the confusion created in a case such as this where there are three separate industrial injury claims superimposed upon a preexisting noncompensable injury, we find there is an easier and more direct way to deal with this case.

Both of claimant's first two compensable injuries were closed by Determination Orders that awarded temporary disability benefits, but no permanent disability benefits. After the second injury, a September 8, 1980 chart note reported that claimant's ulnar neuritis was gone, and that claimant was still able to perform his regular work. It was only after the latest on-the-job injury on June 3, 1981 that the ulnar nerve transposition surgery was required and that Dr. Wright and, eventually, Dr. Vigeland agreed that claimant could not return to his regular work. Therefore, the evidence shows that claimant's present limitations are due at least in material part from claimant's most recent on-the-job injury and, therefore, we assign claimant's permanent disability to his 1981 injury. This makes it unnecessary to remand the 1979 and 1980 injury claims to the insurer for further processing.

Taking into consideration claimant's prior injury, and considering ORS 656.222, we find the Referee properly awarded claimant 20% for 38.4° scheduled permanent partial disability for his left elbow condition.

Regarding the additional temporary disability benefits awarded by the Referee, we affirm that portion of the order. Dr. Wright had the opinion when he examined claimant in April 1982, that his condition was not yet stationary from Dr. Vigeland's surgery. He concluded claimant's condition became stationary on October 8, 1982. As the Referee noted, Dr. Wright based his opinion on a variety of factors including time elapsed since surgery, pain with repetitive movements, significant loss of grip strength which was approximately one-quarter of his normal strength, reduced sensation in his fingers with limitation of range of motion. All these findings and signs were present at the time Dr. Vigeland found claimant stationary in February 1982. However, since April 1982, claimant's condition had improved with the passage of time and, therefore, with the benefit of hindsight it appears that the level of signs and symptoms that Dr. Vigeland viewed in February was not the level at which claimant's condition became medically stationary in October.

In ordering that the 1979 and 1980 claims be remanded, the Referee also set aside the insurer's denial of September 29, 1982. Although it is not entirely clear on what basis claimant made his September 24, 1982 claim or upon which basis the September 29, 1982 denial was issued, it appears reasonable to assume that claimant was claiming an aggravation of his left elbow condition and that the insurer was denying the same. The Referee found that claimant's condition had not worsened since the last arrangement of compensation (the June 14, 1982 Determination Order), and we agree with that finding. With our understanding that the insurer was denying that claimant's condition had worsened since the last arrangement of compensation, we approve the September 29, 1982 denial.

Finally, regarding temporary total disability benefits paid pending Dr. Wright's deposition and the inclusion of Dr. Wright's deposition in the record, we find that under the circumstances and agreements that existed between the parties at the time of Referee Mannix's Prehearing Order and Referee Quillinan's Interim Order, the temporary benefits should be allowed and Dr. Wright's deposition was properly included in the record.

ORDER

The Referee's orders dated April 28, 1983 and July 22, 1983 are reversed in part and affirmed in part. Those portions which set aside the insurer's aggravation denial of September 29, 1982 and remanded claimant's August 8, 1979 and September 28, 1980 industrial injury claims to the insurer for payment of benefits and further processing pursuant to ORS 656.268 are reversed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the SAIF Corporation.

We affirm the remainder of the orders.

ARNOLD L. WEBBER, Claimant
Coons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Moscato & Meyers, Defense Attorneys

WCB 80-03390 & 81-04831
August 15, 1984
Order on Remand

This case comes to the Board on remand from the Court of Appeals. SAIF v. Webber, 66 Or App 463 (1984).

As background, claimant suffered a low back injury in 1976 which SAIF accepted. A July 11, 1980 Determination Order awarded 32° for 10% unscheduled permanent disability, and claimant requested a hearing on extent of permanent disability. In August 1980, while working for an employer insured by EBI, claimant suffered increased back pain after a tire changing incident. EBI initially accepted responsibility for the August 1980 injury, but in September 1981 it denied the claim.

In the meantime, the claim had been closed by an April 1981 Determination Order which then was set aside by a June 1981 Determination Order, finding that claimant was not yet medically stationary. Subsequently, a hearing was held in which the issue was whether SAIF was responsible for the August 1980 incident as an aggravation of the 1976 injury or whether EBI was responsible for a new injury. The issue of extent of permanent disability related to the 1976 injury was also litigated at that hearing.

The Referee split responsibility between SAIF and EBI for the August 1980 incident, finding that the August 1980 incident was both an aggravation and a new injury. The Referee also increased the permanent disability related to the 1976 injury to 30%, found that claimant became medically stationary on both claims on September 8, 1981 and found that the 1980 incident did not result in any permanent disability. The Board affirmed the Referee. 35 Van Natta 247 (1983). The Court of Appeals reversed, found that the tire changing incident was a single incident and a new injury for which EBI is responsible and remanded for determination of extent of disability. SAIF v. Webber, supra.

The Board affirms the Referee's 30% permanent disability award related to the 1976 injury. We decline to rate the permanent disability resulting from the 1980 new injury, however. Although that claim was once closed by Determination Order, that Determination Order was set aside and claimant probably became medically stationary after the second Determination Order issued. Therefore, the 1980 new injury claim has not yet been closed under ORS 656.268. If we found that claimant became medically

stationary prior to the date of the second Determination Order rescinding the first, we would be inclined to determine the appropriate medically stationary date and order the Evaluation Division to issue a Determination Order so stating. In this situation, however, we find that the Referee should not have closed the 1980 new injury claim and that remand of that claim to the Evaluation Division for closure under ORS 656.268 is most appropriate. This decision is a departure from the Board's position in its prior order on this case. 35 Van Natta 247 (1983).

ORDER

The Board affirms the Referee's award of 96° for 30% unscheduled permanent disability resulting from the 1976 injury, SAIF Claim No. D 174931, WCB No. 80-03390. Claimant's attorney is awarded 25% of the increased permanent disability, to be paid out of claimant's compensation. The Board remands the EBI August 1980 claim, C-8015060, WCB No. 81-04831, to the Evaluation Division for closure under ORS 656.268.

SALLY K. CUTTS, Claimant
Susan M. Garrett, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06088
August 20, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Daron's order which awarded claimant 35% (112°) unscheduled permanent partial disability for her vasomotor rhinitis condition, whereas Determination Orders dated May 2, 1983 and May 27, 1983 did not award her permanent disability. On review, SAIF contends claimant's underlying condition was not permanently worsened and that the Referee's award was excessive.

The Board finds that claimant's vasomotor rhinitis condition has permanently worsened as a result of her work activities. However, we believe the Referee's award should be reduced.

Claimant is a 35 year old licensed barber, hairdresser and cosmetologist. She is 6 months from completion of a "stylist" program which would enable her to earn approximately $20,000 per year. However, her treating allergist, Dr. Baker, has advised her not to return to such an environment where she would be exposed to large amounts of several airway irritants. These irritants include "Pine-sol," house cleaners, gasoline, paint, kerosene, perfumes and hair sprays.

When exposed to these irritants claimant experiences severe symptoms. She suffers constant head pain and pressure which feels as if her "whole head was in a vise grip." Dizziness accompanies the pain and pressure. Due to her heightened degree of sensitization, claimant refrains from walking down the "soap" aisle at grocery stores and avoids public areas where she might be exposed to perfumes, room deodorizers, or scented tissues. Her husband no longer uses colognes or deodorants.

Claimant is a pack-a-day smoker. Generally, her smoking does not irritate her condition, unless there are a number of smokers present in a smoky room.

Claimant is a high school graduate. To obtain her license she successfully completed approximately 16 months of beauty school training. Her work experience includes short periods of employment at a trailer factory and at a small grocery store. Additionally, she has worked as a bartender. Due to her susceptibility to airway irritants, claimant felt she could not return to these occupations. Her inability to pursue her career as a beautician has been particularly emotionally debilitating.

Under OAR 436-65-600 et seq., we are required to consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings, and physical impairment, including residual pain, in rating the extent of claimant's disability. Considering the above guidelines and comparing this case to similar cases, we conclude that an award of 15% would more appropriately compensate claimant.

ORDER

The Referee's order dated January 9, 1984 is modified. In lieu of the Referee's award, claimant is awarded a total of 15% (48°) unscheduled disability for her vasomotor rhinitis condition. Claimant's attorney's fee shall be adjusted accordingly.

DONALD G. DOWELL, Claimant
Pozzi, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 82-06780
August 20, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of Referee Menashe's order which: (1) found claimant was not barred from asserting a claim for Dr. Urban's bills; (2) set aside the employer's denial of Dr. Urban's treatment; and (3) awarded penalties and attorney fees for the employer's failure to issue a proper denial of Dr. Urban's treatment. The employer contends that claimant is barred from claiming further medical services, that claimant's condition is not related to her compensable injury in any event, and that penalties and attorney fees are not warranted.

The Board affirms the Referee's finding that claimant is not barred from claiming further medical services. Patricia M. Dees, 35 Van Natta 120 (1983). The Board also affirms the Referee's finding that claimant's condition in March 1982 and thereafter was related to her compensable injury. Regarding penalties and attorney fees, however, the Board reverses.

Although the employer sent the denial of Dr. Urban's treatment to Dr. Urban and not to claimant, and although the denial contained no notice of appeal rights, claimant requested a hearing contesting that denial 20 days after it was issued. The employer's failure to follow proper procedures thus did not cause actual harm to claimant. We previously have held that penalties and attorney fees are not warranted in this situation. Patricia M. Dees, supra.

ORDER

The Referee's order dated January 17, 1984 is affirmed in part and reversed in part. The award of penalties and associated attorney fees is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $50 for services on Board review, to be paid by the self-insured employer.

BARBARA J. ELLIS, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-03314
August 20, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Peterson's order which awarded claimant a total of 40% (128°) unscheduled permanent partial disability for a right and left shoulder, neck and upper back injury, whereas an August 3, 1983 Determination Order had awarded her 5% (16°). On review, SAIF contends the Referee's award was excessive. We agree and modify the award.

Claimant filed her claim while working as a "hand packer" for a food products plant. Her compensable condition has been variously diagnosed as bilateral thoracic outlet syndrome or cervicothoracic strain. Treatment has been conservative.

Claimant described her disabling pain in great detail. If she reaches overhead for a minute or two, holds her hands out for more than two or three minutes, or repetitively uses her hands and arms, she experiences disabling pain across her shoulders and neck, as well as pain and numbness in her arms extending to her fingers. Her hands lack strength, throb and occasionally change color. Claimant also becomes light-headed and dizzy if she holds her arms above her head. Both of her jaws are intermittently sore. She takes prescribed medication on a daily basis. The Referee found claimant credible.

The medical reports document little, if any, objective findings. Dr. Origer, claimant's treating physician, noted in one of his most recent chart notes that claimant's examination was normal, despite subjective pain complaints. The most recent report, authored by Dr. Denker of the Northwest Pain Center, noted full range of motion of the neck with "notable tenderness of the trapezius muscles bilaterally, as well as the paracervical muscles" and a normal back with "notable tenderness over the left greater trochanter."

Dr. Martens, an examining physician, and Dr. Origer agree that claimant should engage in an occupation that does not require overhead work, pushing, pulling or repetitive use of her hands, nor repeated bending, twisting or lifting over 25 pounds. The Callahan Center opined that claimant could lift or carry at least 35 pounds. In a more recent report, the Northwest Pain Center felt that she should be placed in a clerical or sedentary type position.

In addition to her 4 1/2 years at the food packaging plant, claimant has worked in various positions in the food service industry. Specifically, she has worked as a waitress and as a fry cook. She also served for two years as a kitchen supervisor at a

large convalescent hospital where she was responsible for ordering supplies and supervising a staff of four or five. Since her claim, claimant's attempts to work as a cannery worker and cook aide have failed due to her disabling pain. At the time of hearing claimant was working part-time at a sandwich shop. She anticipated becoming a part owner of the shop. Claimant felt that her pain and weakness prevented her from returning to all of her previous occupations except kitchen supervisor, assuming she would not be required to do heavy lifting.

Claimant was 43 years old at the time of hearing. She completed 10 years of schooling, but has received her GED. Aptitude test results place her in the average range.

Pursuant to OAR 436-65-600 et seq., we consider claimant's age, education, work experience, adaptability, mental capacity, emotional state, labor market findings, and physical impairment, including disabling pain, in rating the extent of claimant's disability. Considering the above guidelines and comparing this case to similar cases, we conclude that a total award of 15% would more appropriately compensate claimant.

ORDER

The Referee's order dated January 20, 1984 is modified. In lieu of the Referee's award, and in addition to the 5% (16°) unscheduled disability awarded by the August 3, 1983 Determination Order, claimant is awarded 10% (32°) unscheduled disability for a total award to date of 15% (48°) unscheduled disability for her shoulders, neck and upper back injury. Claimant's attorney's fee shall be adjusted accordingly.

JUDY M. FRIEDRICH, Claimant
Olson Law Firm, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-00874
August 20, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of that portion of Referee Mongrain's order which declined to assess a penalty and attorney fee against the SAIF Corporation for its allegedly unreasonable failure to reopen her claim in January 1983. SAIF had reopened the claim in March 1983 on the basis of aggravation. The Referee found that claimant established entitlement to claim reopening effective on the earlier January date, but that it had not been unreasonable, based on the then-available information, for SAIF to reopen effective on the later March date.

SAIF did not cross-request review. However, in addition to its respondent's brief, SAIF has filed what it terms an "appellant's brief," contending the Referee erred: (1) in awarding claimant additional compensation for temporary disability from September 11 to October 4, 1982; and (2) in finding that claimant established entitlement to aggravation reopening effective in January 1983.

Claimant has moved to strike SAIF's "appellant's brief," contending the only issue properly before us is the penalty issue raised in claimant's brief. The motion is denied. In Jimmie

Parkerson, 35 Van Natta 1247, 1249 (1983), we concluded that a respondent before the Board could raise additional issues in its brief and we would consider such additional issues even though the respondent had not cross-requested Board review. One risk run by a respondent who fails to cross-request review, which we noted in Parkerson, is the loss of jurisdiction should the appellant's request for review be withdrawn.

Another risk involves attorney fees, and is illustrated by this case. When an employer/insurer cross-requests Board review, raises additional issues before the Board, the claimant responds to those additional issues in a reply brief, and the claimant's position prevails, then we award the claimant's attorney an employer/insurer-paid attorney fee for services rendered in having to respond to the additional issue or issues raised by the employer/insurer. See Teel v. Weyerhaeuser Co., 294 Or 588 (1983). We think that same approach should be applicable when we entertain additional issues raised by an employer/insurer as respondent in the absence of a cross-request for review.

On the merits of the issue raised by claimant and the issues raised by SAIF, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated August 16, 1983 is affirmed. Claimant's attorney is awarded $300 for services rendered in responding to the issues raised by SAIF, to be paid by the SAIF Corporation.

DAVID R. GOSS, Claimant
Pozzi, et al., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-11450
August 20, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Leahy's order which set aside its denial of claimant's claim for myocardial infarction.

Claimant was 55 years old at the time of hearing. He has been employed primarily in sales and management for most of his working life. Claimant began working as a salesman with this employer, a Seattle-based company, in June 1979. Claimant testified he was successful, increasing the sales volume in his territory from $100,000 to $300,000 in about a year. However, he stated that his success resulted in jealousy and tension.

In July 1981 claimant's supervisor retired. A meeting with the owner of the company was held in Seattle during the first week of August. Claimant anticipated that he would be promoted to succeed his supervisor; instead, he was advised that he would be terminated effective September 1, 1981. The reason he was given for his dismissal was that the emphasis of the company's product line was changing and that the company was experiencing financial difficulties. Claimant testified that he soon learned that these representations were false. Claimant was quite upset about the termination, the associated apparent lack of candor and the prospect of unemployment.

On August 28, 1981 a trade show began in Portland. Claimant attended the trade show both representing his employer and "for his own account" in the sense that he anticipated meeting a number of potential employers at the show. Claimant testified he was very nervous about looking for work. While driving to the trade show claimant became very nauseous. He thought he was experiencing an ulcer attack.

That same afternoon claimant sought medical attention. An EKG failed to show evidence of any acute injury or ischemia. The diagnosis was esophagitis or esophageal ulcer with spasms. Claimant's fever was interpreted as gastro-enteritis. Claimant returned home, but his pain increased to the point where, early the next morning, he went to a hospital emergency room. Claimant was diagnosed as having peptic disease, given some medication and sent home.

On September 18, 1981 claimant consulted with Dr. Connor, an internist. At that point it had been three weeks since claimant's distress at the time of the trade show and a couple of weeks since claimant's employment ended at the beginning of September. Dr. Connor felt that claimant's pain was suggestive of coronary disease. An EKG was interpreted to show a recent myocardial infarction. Claimant was admitted to the hospital for further testing. Dr. Connor's impression was: (1) recent myocardial infarction; (2) history of peptic ulcer disease; (3) mild exogenous obesity; and (4) borderline blood pressure. Following a radiological consultation, the conclusion was arteriosclerosis with left ventricular hypertrophy. An angiogram demonstrated 2-vessel coronary disease.

Dr. Reaume, the cardiologist who performed claimant's angiograms, reported that he did not feel it was medically possible to state an opinion regarding the relationship between claimant's heart attack and his pre-September job. Dr. Connor reported that coronary artery disease presumably takes years and perhaps a lifetime to develop. The doctor stated that it was certainly possible that claimant's work activity, stress and termination were a contributing factor to his myocardial infarction. Dr. Connor identified other risk factors as being claimant's smoking, family history, lipid abnormalities, lack of exercise, hypertension and obesity. Dr. Connor said he was unable to state an opinion about the relative contribution of claimant's work activity and stress versus these other risk factors.

Dr. Kloster examined claimant and testified at the hearing. Dr. Kloster stated that claimant suffered from underlying and preexisting coronary artery disease. He felt the disease was not caused by the stress of claimant's work activity. However, Dr. Kloster opined that claimant's termination, his brooding over the manner in which it was handled, his anxiety about future employment and his apprehension regarding the trade show all contributed to claimant's myocardial infarction. Dr. Kloster testified: "I think there is a reasonable probability that [the infarction] would not have occurred on that day if he hadn't been under the stress he was going to the trade show."

Dr. Toren, a cardiologist, reviewed claimant's file and issued his report. Dr. Toren disagreed with Dr. Kloster's "prolonged angina" theory. Dr. Toren opined that claimant's myocardial infarction was the result of a natural progression of

his coronary artery disease and that stress related to his job and firing did not play a contributing role.

Dr. Toren cited a number of objective findings as support for his opinion. The coronary angiogram administered prior to claimant's surgery demonstrated a complete occlusion of the right coronary artery. This artery provides the blood supply to the inferior wall of the heart; visual inspection at the time of claimant's surgery revealed this to be the location of claimant's infarction. Dr. Toren opined that, without question, the closure of the right coronary artery was the cause of the myocardial infarction. Dr. Toren further concluded that no form of stress or exertion would reasonably be expected to contribute to the closure of a coronary artery.

Dr. Toren explained that prolonged angina episodes are rare, are associated with a subtotal closure of a coronary artery and could not, in the doctor's opinion, lead to an infarction. Dr. Toren noted that claimant's artery was subsequently found to be completely closed, which when associated with a heart attack, is known to be caused by coronary thrombosis. A thrombosis, according to Dr. Toren, is not something that patients can bring on by their actions or by the circumstances of their life. There is no known set of circumstances which can cause the development of the thrombosis or occlusion.

The Referee found the claim compensable. He reasoned that Dr. Kloster had advantages over Dr. Toren because Dr. Kloster had the opportunity to examine claimant and because Dr. Kloster testified at the hearing.

We disagree with the Referee's conclusion. We will assume for sake of discussion that the infarction probably occurred in late August, while claimant was still employed. We will assume for sake of discussion that a heart attack associated with a worker being upset over being discharged is as compensable as a psychiatric illness associated with a worker being upset over being discharged. See Elwood v. SAIF, 67 Or App 134 (1984).

Nevertheless, there is a serious conflict in the medical opinions in this record concerning the possible causal connection between claimant's work (and termination of work) stress and his myocardial infarction. Unlike the Referee, on de novo review we are unable to conclude that Dr. Kloster's opinion is the most persuasive in the face of Dr. Toren's contrary opinion which is supported by the angiogram results, a Swedish study and by visual examination of the occluded coronary artery at the time of bypass surgery. Moreover, all doctors involved seem to agree that claimant had a large number of nonvocational risk factors which could have contributed to his infarction. Finally, although we think it is entitled to relatively little weight, we note that the other specialists involved, including claimant's treating doctors, acknowledged the difficulty in establishing a causal relationship between claimant's infarction and his job stress.

For all of these reasons, we are not persuaded that claimant has proven a materially causal connection between his work activities and his myocardial infarction.

ORDER

The Referee's order dated July 7, 1983 is reversed. The SAIF Corporation's denial dated December 3, 1981 is reinstated and affirmed.

ANTON F. MORTENSEN, Claimant
Doblie & McSwain, Claimant's Attorneys
Miller, et al., Defense Attorneys

WCB 82-11538
August 20, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Gemmell's order which awarded claimant permanent total disability in lieu of the 80° for 25% unscheduled disability previously awarded by Determination Order. The employer contends that claimant is not permanently totally disabled.

The Board agrees with the employer and reverses.

We make the following findings of fact. Claimant was compensably injured in December 1979 while working as a machinist for the employer school district. As a result claimant suffered a compression fracture of T-12 and eventually had a spinal fusion with insertion of Luque rods from T-9 to L-2. In June 1983 claimant's treating doctor, Dr. Carr, stated that claimant could return to some kind of work, providing it was extremely light and geared to his limitations. Dr. Carr limited claimant to sitting one hour at a time, standing one hour at a time, walking one-half hour at a time, total sitting four hours in an eight hour day, total standing four hours in an eight hour day, and walking two hours in an eight hour day. Claimant is not to lift over 20 pounds, to crouch, kneel, crawl, or climb, and only occasionally to bend, twist, walk on uneven ground or climb stairs.

The Orthopaedic Consultants examined claimant in June 1983 and diagnosed: (1) compression fracture, T-12; (2) postoperative spinal fusion, L-2 to T-9, with Luque rods and wire; (3) radiculitis, left thoracic; and (4) chronic degenerative joint disease, L-4 to S-1. The panel rated claimant's impairment in the thoracic and lumbar spine due to this injury to be mildly moderate. In addition, the panel stated that claimant is not capable of performing his previous employment or any occupation requiring physical activity of any magnitude, but that claimant is capable of working in the light to sedentary category.

Claimant suffers pain in the left shoulder, left rib cage and around to his chest. He also has low back and leg pain and he no longer hunts, fishes, dances or bowls. Furthermore, claimant is 45 years old, has a high school education and has work experience as a reserve deputy sheriff in addition to his machinist experience. Claimant also has significant experience in the labor movement, including holding positions as shop steward, chairman of shop stewards, and delegate to district and national conventions. In addition, claimant has typing and bookkeeping skills. Intelligence testing revealed that claimant has a full scale I.Q. of 125, which is the 95th percentile and rated as superior. Vocational reports also portray claimant as extremely affable, easy mannered, able to converse at any level, and as generally giving a good impression of himself.

Claimant's vocational counselor, Linda Hill, testified that she was arranging for a training program for claimant in dispatching with the Oregon State Police, but the program was not yet approved. Dr. Carr had reviewed the physical requirements and had approved claimant working as a dispatcher, which would allow claimant to sit or stand as he chooses. Ms. Hill stated that claimant was not employable as a dispatcher without specific training and that he was not employable in a competitive job without retraining. At other times during her testimony, however, Ms. Hill stated that claimant has skills and aptitudes to do some kind of work and that claimant was bright enough to do mentally whatever he wants.

After his injury but before his surgery, claimant returned to light duty with the employer school district, which employs about 7000 employes. The light duty positions held by claimant included work in security monitoring TV screens, public relations, and safety inspection. Prolonged sitting and typing at a desk caused claimant increased back pain. Claimant attempted to return to the school district after his surgery but the district was not able to place claimant in a position within his physical capabilities. The record does not indicate that the district had no jobs that claimant could perform, but rather, that the district had no jobs open and available that claimant could perform. Except for the prolonged sitting at one job, claimant did not claim to be unable to perform the other light duty school district jobs he had previously held.

Claimant has applied for other jobs since being released for light duty, including positions as a union business representative and as a maintenance supervisor. Although claimant was not chosen for those positions, the record contains no evidence that claimant was not able, physically and mentally, to perform those jobs. Claimant also testified that he believed he could perform tool sales work, but did not have the financial resources to get into that business independently.

Considering claimant's mental capacity, work experience and the jobs he has attempted to obtain, we cannot agree with the Referee's finding that claimant has no transferable skills. We also cannot accept Ms. Hill's testimony that claimant is not competitively employable without retraining, in light of the remainder of her testimony and the other evidence that suggests otherwise. We do not have to decide whether the training for the dispatcher job is more than just "learning the ropes" of a new job, as we are convinced that claimant is able to perform other jobs without retraining. Although claimant's impairment is certainly significant, he is not permanently totally disabled from a medical standpoint. Furthermore, he is fortunate to be of a relatively young age and to have a high intelligence level and various work skills that he can use in sedentary jobs.

Therefore, we find that claimant is not incapable of "regularly performing work at a gainful and suitable occupation," ORS 656.206(1)(a), and thus is not permanently totally disabled. We find, however, that claimant is entitled to a permanent disability award greater than the 25% awarded by Determination Order. Considering claimant's impairment, including disabling pain, his age, education, work experience, adaptability, mental

capacity and other relevant social and vocational factors, and comparing this case with other similar cases, we find that claimant is entitled to an award of 70% unscheduled permanent partial disability.

ORDER

The Referee's order dated December 12, 1983 is reversed. Claimant is awarded 224° for 70% unscheduled permanent disability, in lieu of all prior awards.

CHARLIE W. OWEN, Deceased
Pozzi, et al., Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-11633
August 20, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The deceased worker's widow (hereinafter "claimant") requests review of Referee Foster's order which concluded that the Workers' Compensation Act does not provide for a claim such as claimant here asserts -- that she should receive death benefits based on proof in this proceeding that the deceased worker, who had been found to be partially disabled before his death, was totally disabled at the time of his death. Alternatively, on the merits, the Referee also concluded that the deceased worker was not totally disabled at the time of his death; claimant also challenges this finding on review.

The principal issues raised involve interpretation and application of ORS 656.208. As here relevant, that statute provides that if an "injured worker dies during the period of permanent total disability, whatever the cause of death," then the worker's surviving spouse shall receive benefits "in the same manner and in the same amounts as provided in ORS 656.204." In turn, ORS 656.204 provides for survivor's benefits when a death results from an industrial injury. Thus, the benefits available under these two statutes are the same, but the entitlement standards are different. ORS 656.204 applies when death is caused by an industrial injury or occupational disease. ORS 656.208 applies regardless of the cause of death, but only if "the injured worker dies during the period of permanent total disability."

There are two possible interpretations of this statutory language. First, it could apply when the injured worker, while he was still alive, was granted an award for permanent total disability. Basically, the Referee so interpreted ORS 656.208. Or that statute could create a right of every surviving spouse of every injured worker -- meaning hundreds of thousands of potential claimants -- to request a hearing on the question of whether the worker was totally disabled at the time of death. Claimant argues for this latter interpretation.

The deceased worker sustained a compensable back injury in November of 1967. The claim was closed, reopened and reclosed several times over the years, resulting in a series of Determination Orders and an Own Motion Order which granted the deceased worker a total award of 35% unscheduled permanent partial disability. The worker died in September 1982 from causes unrelated to his 1967 industrial injury. In short, the deceased worker had never been found to be totally disabled before his

death but, instead, had been found several times to be partially disabled; nevertheless, claimant now seeks in this proceeding to establish that the worker was totally disabled when he died, i.e., that he died "during the period of total disability" within the meaning of ORS 656.208.

We do not interpret the statute as contemplating or authorizing this kind of claim. We believe that ORS 656.208 is only applicable when an injured worker has, prior to his or her death, been found to be totally disabled. The reference to death "during the period of total disability" has been in ORS 656.208 for more than 30 years and, over all those years, it has never been previously suggested that the legislature intended this language to authorize every surviving spouse of every injured worker who received a partial disability award while living to claim death benefits because the worker was really totally disabled at the time of death.

Further indication of the lack of any such legislative intent comes from a somewhat related statute, ORS 656.218, which permits the survivors of a deceased worker to initiate or continue litigation regarding the extent of the worker's disability if no final decision on that question was rendered before the worker's death. If ORS 656.208 were interpreted to permit every surviving spouse of every partially disabled worker to litigate the question of total disability after death, then the concept in ORS 656.218, i.e., continued litigation after death if there were no final decision before death, is rendered meaningless.

Claimant's arguments in this case do not suggest any reasons to believe the legislature intended to create the right to assert this kind of claim. Instead, claimant's arguments are built on an assortment of phrases and clauses from appellate court decisions, none of which are directly relevant to interpretation of ORS 656.208.

Claimant argues that her claim is an "independent right of action" which did not arise until her husband's death, citing Mikolich v. SIAC, 212 Or 36 (1957), and Fossum v. SAIF, 289 Or 787 (1980). We doubt that Mikolich has much continuing vitality; that case was concerned with the procedural issues now addressed in ORS 656.218, but was decided before ORS 656.218 was enacted. It would appear that the newer statute rather than the older case law is now controlling. See Bradley v. SAIF, 38 Or App 559 (1979). Moreover, it begs the question to focus on the "dependence" or "independence" of a cause of action when the question before us is whether the legislature intended to create any cause of action.

In Fossum the worker died of an occupational disease, but could not have asserted a claim himself before his death because his claim would have been barred by the statute of limitations. His widow filed a claim. The court held that the right of a surviving spouse is independent from the right of the deceased spouse, and that the statute of limitations did not apply to the claim of the surviving spouse, who acquires a new right under ORS 656.204 at the time of a death due to an occupational disease. Fossum is obviously distinguishable because there is no contention here that the worker died as a result of an industrial injury or an occupational disease, and thus no rights are here claimed under ORS 656.204. More importantly, and to repeat, to say that a

surviving spouse's rights under one statute (ORS 656.204) are "independent" sheds very little light on the scope of a surviving spouse's rights under a different statute (ORS 656.208).

The case that appears most relevant to us is Mayes v. Boise Cascade Corp., 46 Or App 333 (1980). Mayes seems to break all possible cases of this general type down into three categories:

(1) Cases in which there has been no final determination of the extent of the deceased worker's disability during his or her lifetime. In these cases, ORS 656.218 permits the worker's survivors to pursue the extent-of-disability issue.

(2) Cases in which there was a final determination during the worker's lifetime that the worker was totally disabled. Mayes holds that in these cases the worker's survivors receive benefits pursuant to ORS 656.208 without the need to prove that the worker remained totally disabled at the time of death; at least to this extent, it would seem that the survivors' ORS 656.208 rights are more derivative than independent.

(3) Cases in which there was a final determination during the worker's lifetime that the worker was not totally disabled, but was only partially disabled. This case falls into this category. Mayes is the least clear on the question of what happens to cases in this category, with statements like "a widow may . . . possibly 'relitigate' the extent of a deceased worker's disability at the time of his death in attempting to obtain benefits under ORS 656.208." 46 Or App at 340. Despite this lack of clarity, however, we conclude that the thrust of Mayes is inconsistent with permitting such "relitigation." Mayes is clear in holding that the survivors get the benefit of a prior determination that the worker was totally disabled, and need not relitigate this issue in order to obtain benefits pursuant to ORS 656.208. It thus seems reasonable that the survivors should also bear the burden of a prior final determination that the worker was not totally disabled, and not be able to relitigate this issue.

For all of these reasons, we conclude that when there has been a final determination during a worker's lifetime that the worker is partially, not totally disabled, and when none of the procedures spelled out in ORS 656.218 are available to the worker's survivors when he or she dies, ORS 656.208 does not create a right in the survivors to attempt to establish that the worker was totally disabled at the time of death.

Claimant raises another issue regarding interim compensation, penalties and attorney fees. The relevant facts are poorly developed in the record. Apparently claimant made a claim for death benefits in September 1982, although it would be impossible to say when anyone knew or reasonably could have known that the claim was predicated on claimant's interpretation of ORS 656.208. SAIF denied the claim on January 10, 1983. However, subsequent letters from SAIF to claimant dated January 18, 1983 and February 17, 1983 suggest that some form of benefits were being paid. Before the worker's death, an Own Motion Determination, issued in June 1982 in connection with the continued processing of the worker's 1967 injury claim, had created an overpayment of $706.76. Apparently, although we repeat that the record is far from clear, SAIF setoff (or asserted a right to setoff) this prior

overpayment against some form of benefits (interim compensation?) it paid to claimant.

In any event, claimant's argument on this point is reasonably clear: (1) that she was entitled to interim compensation between the date of her claim in September 1982 and the date of SAIF's denial in January 1983; and (2) that SAIF is prohibited by Forney v. Western States Plywood, 66 Or App 155 (1983), from recouping its prior overpayment by unilaterally reducing claimant's interim compensation. We agree with claimant's second point. However, we disagree with claimant's first point, which is the foundation of claimant's whole position on this issue.

There are very few exceptions to the duty to pay interim compensation. One exception is stated in Bell v. Hartman, 289 Or 447 (1980). The question in that case was whether interim compensation had to be paid to a claimant who was found not to have been an employe of any of the employers against whom he asserted alternative claims. The Supreme Court answered that question in the negative, based on its conclusion "that one who is not a 'worker' within the definition of ORS 656.005(31) [since renumbered ORS 656.005(28)] also is not entitled to 'interim' compensation pending denial of his claim under ORS 656.262." 289 Or at 452.

We find this concept is also applicable in this case. Interim compensation did not have to be paid to the claimant in Bell because, as a matter of law, a person who is not an employe can have no possible claim under ORS chapter 656. Likewise, in this case, we have interpreted ORS 656.208 to provide that, as a matter of law, this claimant has no right to assert a claim founded on that statute. For all of the reasons stated in Bell, we do not think that claimant was entitled to interim compensation in these circumstances.

Therefore, any payments that SAIF made to claimant or her children were gratuitous and the issue of a setoff, unilateral or otherwise, is irrelevant.

ORDER

The Referee's order dated October 7, 1983 is affirmed.

HOWARD RICE, Claimant
Richard Condon, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 82-07181
August 20, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Quillinan's order which set aside its August 3, 1982 denial of claimant's occupational stress claim. The employer argues that claimant's emotional disability was not caused by work-related stress but by an unrelated endogenous depression.

The Board affirms the order of the Referee with the following comments.

We make the following findings of fact. Claimant is a 56-year-old male who, at the time of the events leading to his

workers' compensation claim, worked as a foreman for the City of Salem Water Department. In 1978 several changes occurred in claimant's job, including the hiring of a new superintendent and a promotion for claimant which resulted in new duties for him. Thereafter, claimant received evaluations that were critical of his job performance. In November 1978 claimant was demoted and later was reprimanded and suspended for three days without pay. Claimant ceased working in April 1982 and in September 1982 he was terminated. During this time, claimant had no off-the-job stressors.

In the meantime, claimant came under the care of Dr. Maltby, psychiatrist. Dr. Maltby stated that claimant was suffering from reactive depression or adjustment disorder with mixed emotional features related to work stress. Claimant was seen once by Dr. Parvaresh, who diagnosed "endogenous depression," which arises from physiological causes and which was unrelated to claimant's work.

The Referee stated that whether claimant's perception of the events was well-founded is irrelevant. The Referee relied on McGarrah v. SAIF, 59 Or App 448 (1982), which provided that a stress claim could be found compensable if a claimant perceived that some event or events occurred during the course of employment which caused the stress related condition, even if those events were not real. Since the date of the Referee's order, however, the Supreme Court decided McGarrah v. SAIF, 296 Or 145 (1983), which held that the stress conditions must actually exist on the job and that those conditions must be real when viewed objectively.

Subsequently, the Court of Appeals stated that McGarrah poses the following questions:

> "1. What were the 'real' events and conditions of plaintiff's employment?
>
> "2. Were those real events and conditions capable of producing stress when viewed 'objectively,' even though an average worker might not have respond [sic] adversely to them?
>
> "3. Did plaintiff suffer a mental disorder?
>
> "4. Were the real stressful events and conditions the 'major contributing cause' of plaintiff's mental disorder?" Elwood v. SAIF, 67 Or App 134 (1984).

We have reviewed the record to determine whether the events and conditions described by claimant were real; if so, whether those real events and conditions were capable of producing stress when viewed objectively; whether claimant suffered a mental disorder; and whether the real stressful events and conditions were the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145 (1983); James v. SAIF, 290 Or 343 (1981); SAIF v. Gygi, 55 Or App 570 (1982).

We find that the events and conditions described by claimant

actually happened and existed, that is, they were "real." Furthermore, we find that those events and conditions, when viewed objectively, were capable of producing stress. In addition, we are persuaded by Dr. Maltby's opinion and, therefore, we find that claimant suffered the mental disorder diagnosed by Dr. Maltby and that the major contributing cause of that disorder was the stressful occupational events and conditions described by claimant. Accordingly, we agree that claimant's psychological stress claim is compensable.

ORDER

The Referee's order dated August 5, 1983 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

GERALD T. DILLEY, Claimant
Peter Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08775
August 22, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Claimant requests review of those portions of Referee Knapp's order which declined to award a penalty and attorney fee based on the SAIF Corporation's termination of time loss benefits following a vocational rehabilitation program, and which ordered that SAIF need not pay claimant further time loss benefits because he was released to work.

Claimant's claim for a June 1979 elbow injury has been closed, reopened and reclosed several times for medical treatment and various vocational rehabilitation efforts. In September 1982 while claimant was in a training program and his claim was thus in open status, he fractured the fourth toe of his left foot. Dr. Noall treated the toe injury and almost immediately released claimant to return to work, although there is some ambiguity in the record about the actual release-to-work date. Claimant's training program was terminated at about that same time.

There was some confusion in the processing of this claim between September 1982 and January 1983, but ultimately a Determination Order was issued toward the end of January. The Referee found that this Determination Order prematurely closed claimant's claim because his toe condition was not then medically stationary, and no issue is raised on review concerning that finding. (Nor is there any contention that claimant's elbow, which was injured in 1979, was other than medically stationary in 1983.)

The Referee awarded claimant additional temporary total disability from December 16, 1982, when SAIF had stopped paying time loss, to January 28, 1983, when the Determination Order was issued. Although no issue is specifically raised on review regarding this award, we have to mention some doubts about it in connection with the penalty issue. The Referee's award of additional time loss after termination of claimant's training program and before the Determination Order was issued was based on Billy Joe Jones, 34 Van Natta 655 (1982), 34 Van Natta 738 (1982), aff'd Boise Cascade Corp. v. Jones, 63 Or App 194 (1983). True, Jones generally requires that temporary total disability be paid

following completion or termination of a vocational rehabilitation program until a Determination Order is issued. But we do not interpret any of the decisions in the Jones case as having been intended to displace all other applicable rules. One other applicable rule is that benefits for temporary total disability need not be paid to a claimant who has been released for regular work. In other words, the general rule of Jones (time loss should be paid following a rehabilitation program until a Determination Order is issued) has to be understood to be subject to the qualification that time loss need not be paid to a claimant who has been previously released to regular work.

The Referee recognized this qualification in deciding the second issue raised on review: Whether, when a Determination Order is set aside as premature, a claimant must necessarily be paid time loss benefits. The Referee answered that question in the negative because, even though the January 1983 Determination Order was premature because claimant's toe condition was not medically stationary, the doctor treating the toe condition had released claimant to regular work in September or October 1982. We believe there is something of an internal contradiction between (1) awarding additional time loss for December and January, which the Referee did, even though claimant had been released for work at least two months before, and (2) not awarding additional time loss beyond January, which the Referee also did, because of claimant's prior work release. We do not understand Jones to require any such contradiction.

In summary, as to the specific issues raised on review, as specifically argued on review, we conclude: (1) there is no possible basis for imposing a penalty and associated attorney fee because of SAIF's nonpayment of temporary disability from December 16, 1982 to January 28, 1983 -- SAIF was not required to pay temporary disability benefits during this period because of claimant's prior work release; (2) we will not, however, reverse the Referee's award of additional temporary disability benefits for this period because no party has requested such relief; and (3) for the same reason that claimant was not entitled to additional temporary disability benefits for the December/January period, that is, his prior work release, the Referee correctly concluded that claimant was not entitled to additional temporary disability benefits beyond January 28, 1983 unless his "treating physician authorizes future time loss because of a worsened condition or as a result of medical treatment."

ORDER

The Referee's order dated April 11, 1983 is affirmed.

ROBERT L. FOWLER, Claimant
Callahan, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-05886
August 22, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Wilson's order which upheld the SAIF Corporation's denial of claimant's aggravation claim.

Claimant sustained a compensable injury in April of 1975.

His claim was first closed on October 7, 1975; claimant's aggravation rights thus extended five years from that date.

In September of 1980, Dr. Gerstner recommended that claimant undergo surgery for the consequences of his 1975 injury. Claimant accepted this recommendation, and Dr. Gerstner performed surgery on October 9, 1980, i.e., two days after claimant's aggravation rights had expired. The circumstances of notice to SAIF that surgery was planned or had been performed are disputed, but at some point SAIF learned of the surgery and at first, in January 1981, reopened claimant's claim on the basis of aggravation and began paying time loss. Later, in August 1981, SAIF reversed its position and ceased paying time loss on the ground that claimant's aggravation rights had expired before Dr. Gerstner performed surgery in October 1980. SAIF has paid for the cost of the surgery and related medical expenses pursuant to ORS 656.245; so the present dispute involves only claimant's entitlement to compensation for temporary disability.

The first issue is whether claimant perfected an aggravation claim before his aggravation rights expired. Claimant does not contend that any written claim was asserted before his aggravation rights expired. Rather, claimant argues that, factually, a claim was asserted on his behalf by way of a telephone call from Dr. Gerstner's office to SAIF and that, legally, an oral aggravation claim is sufficient under ORS chapter 656.

SAIF's records indicate that it did not receive any information about the surgery until sometime after it had been performed which, of course, would have been after claimant's aggravation rights had expired. Dr. Gerstner testified that he believed that his office telephoned SAIF to obtain permission for the surgery. The doctor seemed certain he would not have proceeded with surgery without prior authorization. SAIF's claims manager testified that there was no record of any telephone call from Dr. Gerstner's office in connection with this claim, and that no one at SAIF had authority to authorize surgery by telephone. He admitted, however, that it is possible that someone authorized the surgery without authority to do so.

The Referee concluded that an aggravation claim must be in writing and thus that claimant had failed to perfect an aggravation claim prior to the expiration of his aggravation rights. Although there is some ambiguity in ORS chapter 656, we agree with the Referee that the better policy position is that an aggravation claim must be in writing.

ORS 656.005(7) defines a claim as "a written request for compensation" or, disjunctively, "any compensable injury of which a subject employer has notice or knowledge." Under the second half of this definition, it is clear that an initial claim need not be in writing and that just the employer's knowledge that a worker was injured while working amounts to a "claim." See also ORS 656.262(3) which, by implication, defines a claim as including an employer's knowledge of an "accident which may result in a compensable injury claim." ORS 656.262(3) also requires an employer to notify its insurer of any and all claims. Once the employer does so, all further claim processing obligations fall on the insurer. ORS 656.262(1).

Against this background, the aggravation statute provides that: "To obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the insurer or self-insured employer." ORS 656.273(2) (emphasis added). In context, we believe that the statutory reference to filing a claim with the insurer was deliberate. While a claim can begin based solely on the employer's knowledge of an accident, an insured employer is not further involved in the processing of the claim; the duty to process the claim falls entirely on the insurer. While an employer is generally in daily contact with its employes, which reasonably enables the employer to know about at-work accidents and resulting injuries, there is no comparable relationship between a claimant and an insurer.

We think it follows that the legislature likely intended that there be some more formal claim-notification process between a claimant and an insurer. That intent is expressed in ORS 656.273(2) through the requirement that an aggravation claim be "filed . . . with the insurer." Both the plain meaning of "to file" and the apparent legislative desire for a more formal notification process between a claimant and an insurer point toward a single conclusion: That an aggravation claim must be in writing.

Moreover, the facts of this case indicate the problems that would be created by permitting oral aggravation claims, specifically the factual problem of proving or disproving whether an oral "aggravation claim" was ever asserted. If we were to reach that factual issue in this case, we would confront a conflict between (1) Dr. Gerstner's understanding of the procedures he wants his office staff to follow (obtain prior authorization for insurer-paid surgery) and (2) SAIF's claims manager's understanding of the procedures SAIF wants followed in the claims department (no authorization for surgery by telephone), with no party being able to offer any direct evidence of which procedures were actually followed in this case.

There are already enough problems of proof in aggravation cases. For example, even when an alleged aggravation claim is conveyed to an insurer in writing, questions often arise of whether enough was really said to amount to an aggravation claim. These problems would be compounded, to say the least, if oral aggravation claims were permitted.

For all of these reasons, we agree with the Referee's conclusion that SAIF properly denied claimant's aggravation claim on the ground that no written aggravation claim was filed before claimant's aggravation rights expired.

We also note that there is a possible argument in this case based on the facts that SAIF at first accepted claimant's aggravation claim and later issued a "backup" denial of it, that argument being that SAIF's backup denial is precluded by Bauman v. SAIF, 295 Or 788 (1983). We believe that Bauman is not applicable in this context. Bauman involved interpretation of ORS 656.262; however, ORS 656.262 becomes irrelevant when aggravation rights expire. Once aggravation rights have ended, a claim then falls under the Board's own motion jurisidction, ORS 656.278, and a claimant has no further right to receive time loss benefits. An insurer may nevertheless voluntarily pay time loss benefits, but any such payment is in the nature of largesse and the termination

of such voluntary payment is not in the nature of a denial. Hazel M. Willis, 35 Van Natta 1750 (1983). Bauman does not preclude an insurer from stopping benefits which it never had an obligation to pay.

ORDER

The Referee's order dated May 26, 1983 is affirmed.

TERRI L. KUHN (REEDY), Claimant
Hoffman, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01668
August 22, 1984
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Foster's order which set aside its denial of claimant's aggravation claim. SAIF contends claimant's current low back condition is not related to her 1981 industrial injury and has not worsened.

Claimant sustained a compensable injury in March 1981 when she was thrust against a wall by an unruly horse. Her condition was diagnosed as lumbar strain and contusion of the sacrum and sacrococcygeal function. X-rays revealed that claimant had significant congenital defects, i.e., a pronounced lumbar lordosis and prominently curved sacrum. Following conservative treatment, her claim was closed without an award for permanent disability. Claimant subsequently received 10% permanent disability by virtue of a Referee's order in May 1982.

In December 1982 claimant returned to her treating physician, Dr. Wong. Claimant complained of low back and occasional right leg pain. Claimant had last seen Dr. Wong in April 1982, at which time she also described low back pain with an occasional radicular component to the right leg.

In the December 1982 examination, Dr. Wong recorded a history that, since claimant's last visit the prior April, she had moved to Seattle and then moved back to the Eugene area. Also, claimant had recently given birth prematurely by Caesarean section. Dr. Wong diagnosed "chronic lumbosacral strain-exacerbation"; and recommended claimant continue her back exercise program, briefly reinstitute her physical therapy program and follow-up in two to three months.

In response to SAIF's request for further information, Dr. Wong reported that claimant experienced a mild subjective decrease in sensation on the left at L-4, but that there were no objective findings to suggest discogenic involvement. Dr. Wong reiterated his diagnosis of chronic lumbosacral strain, opining that claimant was employable subject to limitations.

In February 1983 claimant was interviewed by Dr. Kurlychek, a psychologist. Dr. Kurlychek reported that claimant stated that her back condition had been improving until shortly after her child's birth, and that she may have lifted too many heavy items while moving. Dr. Kurlychek reported that claimant admitted that these incidents may have contributed to the return of her back symptoms.

In July 1983 Dr. McHolick, orthopedist, examined claimant and reviewed x-rays and myelograms taken prior to claimant's last arrangement of compensation and after her recent alleged increase of symptoms. Dr. McHolick had previously examined claimant in June 1981. After the 1983 examination, Dr. McHolick reported that he found no evidence of major neurologic or orthopedic problem, other than claimant's congenital abnormality. Dr. McHolick opined that claimant's findings in 1983 were no different than the findings had been in 1981, and that claimant's 1983 problems were not related to her industrial injury.

After reviewing Dr. McHolick's report, Dr. Wong did not disagree that claimant suffered from a congenital abnormality. However, Dr. Wong continued to opine that the 1981 industrial injury precipitated claimant's 1983 symptoms.

The Referee found Dr. Wong's opinion more persuasive than Dr. McHolick's opinion. In one part of his order, the Referee seems to have reasoned that Dr. Wong's opinion should be found more persuasive in this proceeding because a different Referee found Dr. Wong's opinion more persuasive in a prior proceeding. We do not think that any such analysis is viable. "The contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medical opinion." Giesbrecht v. SAIF, 58 Or App 218, 219 (1982).

We thus assess the relative weight of the medical opinions in this record. First, it is not at all clear that claimant's condition is worse now than it was at the time of the last award of compensation; claimant's current symptoms seem to mirror her symptoms at the time of the prior extent-of-disability hearing, and there is no persuasive evidence of any objective change in claimant's condition since that prior hearing. Second, even assuming there has been a worsening, we are not persuaded by Dr. Wong's opinion of a causal link to claimant's rather minor industrial injury. The record indicates a number of other as plausible explanations or more plausible explanations for claimant's current symptoms, specifically her congenital spinal defects, the birth of her child and her move to Seattle and back.

ORDER

The Referee's order dated December 30, 1983 is reversed. The SAIF Corporation's denial dated January 28, 1983 is reinstated and affirmed.

Board Member Lewis Dissenting:

I would affirm the Referee's order which set aside the SAIF Corporation's denial of claimant's aggravation claim.

The Referee noted that when Dr. McHolick examined claimant prior to the first hearing, he did not find any permanent impairment related to the industrial injury. The Referee in the first hearing rejected the medical opinions that claimant suffered no permanent impairment as a result of the industrial injury and awarded claimant 10% permanent disability. SAIF did not appeal

this order. In July 1983 Dr. McHolick stated that claimant's condition had not changed since he last saw her. The Referee stated, "Dr. Wong who originally found some permanent disability, now feels that she has aggravated her condition. I am therefore more inclined to accept the opinion of Dr. Wong over that of Dr. McHolick."

I cannot agree with the majority's implication that the Referee reasoned that Dr. Wong's opinion has to be found more persuasive in this proceeding because another Referee found his opinion more persuasive in another proceeding. I interpret the Referee's reasoning to be that he would not accept Dr. McHolick's opinion over Dr. Wong's because Dr. McHolick's fundamental impression is that claimant has no impairment as a result of her industrial accident, which is contrary to the law of this case that claimant has 10% permanent disability.

I would find that claimant has met her burden of proving that her aggravation is compensable. I would affirm the Referee's order and, therefore, I respectfully dissent.

MICHAEL T. SIMKOVIC (Deceased), Beneficiaries of
Galton, et al., Attorneys
Meyers & Terrall, Defense Attorneys

WCB 83-06258
August 22, 1984
Order on Reconsideration

The Board issued its Order of Dismissal in this case on July 25, 1984, which held that the Referee's order awarding an attorney fee of $1,000 in connection with penalties was an interim order and that the insurer's request for review was premature. Claimant now requests reconsideration, submitting in support a Stipulation and Order of Dismissal dated February 7, 1984. The insurer has responded to claimant's motion. The insurer first raises issues in its response that were not raised in its request for review, and we have not considered those issues. Alternatively, the insurer joins claimant in requesting that the Board review the attorney fee issue inasmuch as all other issues have been resolved by the above-mentioned stipulation. On reconsideration, the Board vacates its Order of Dismissal and decides the attorney fee issue raised by the insurer on review.

After the Evaluation Division issued a Determination Order ordering payment of death benefits to the beneficiaries of the deceased worker, the insurer denied further benefits. A show cause hearing was held, and the Referee ordered the insurer to pay the benefits ordered by the Determination Order and awarded claimant a penalty of 25% of the benefits due and an associated attorney fee of $1,000. The insurer requested review of that order, raising only the issue of the attorney fee amount. The parties did not litigate at the hearing before the Referee the merits of the insurer's denial, which has now been resolved by the February 7, 1984 stipulation.

In considering the attorney fee issue raised by the insurer, the Board agrees with the insurer that the $1,000 fee is excessive in light of the efforts expended and the results obtained by claimant's attorney at the show cause hearing. The hearing involved three admitted exhibits and resulted in 14 pages of transcript and the Referee's order as discussed above. We find that an attorney fee of $400 more appropriately compensates claimant's attorney for his services in the show cause matter.

ORDER

The Referee's order dated July 27, 1983 is modified. Claimant's attorney is awarded $400 for services at the show cause hearing, in lieu of that awarded by the Referee. The remainder of the Referee's order is affirmed.

THOMAS A. TEST, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-10254, 82-10255, 82-10256 & 82-08544
August 22, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer, Consolidated Freightways, requests review of Referee Knapp's order which set aside its October 22, 1982 denial of claimant's aggravation claim made in connection with his February 22, 1980 industrial injury. The issues on review are compensability, employer/insurer responsibility and the reasonableness of the attorney's fee awarded by the Referee. Both employers/insurers contend that the Referee's award of a $2,480 attorney's fee is excessive.

By an order dated January 25, 1983 the Board referred claimant's request for own motion relief in connection with a 1975 back injury claim which occurred while claimant was employed by Providence Hospital, who was insured by Aetna Insurance Company, for consolidation with claimant's pending hearing request in WCB Case Nos. 82-08544, 82-10254, 82-10255 and 82-10256. The Referee conducted a consolidated hearing, and in addition to entering his order pursuant to ORS 656.289, which we presently have before us on review, he made a recommendation to the Board with respect to claimant's request for own motion relief in the 1975 claim. We have this day entered a separate order in Own Motion No. 83-0007M.

Although there appears to be some issue concerning whether the self-insured employer sufficiently raised the compensability issue on Board review, we resolve this apparent issue in favor of finding that it was. Compensability of claimant's condition on and after August 8, 1982 was specifically designated as an issue in the employer's request for review. We believe the preponderance of the evidence clearly supports the Referee's finding that claimant has suffered a compensable worsening of his injury-related condition. Accordingly, we affirm the Referee's order with respect to the issue of compensability of this aggravation claim.

With regard to the issue of employer/insurer responsibility for claimant's aggravation claim, we find it to be a very close question. On our de novo review of the record, we agree that the Referee correctly assigned responsibility to Consolidated Freightways in connection with claimant's February 22, 1980 industrial injury. See also Duane Kearns, 35 Van Natta 772, 35 Van Natta 779 (1983).

With regard to the issue of attorney fees, we find that the Referee's award is excessive. Considering the efforts expended and results obtained in behalf of claimant, OAR 438-47-010(2), we believe that $1,700 is a reasonable fee for services before the Referee. Claimant's attorney is entitled to a fee on Board review

for services rendered on the compensability/responsibility issue. See also Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated May 25, 1983 is modified in part. In lieu of the Referee's award of attorney fees, claimant's attorney is awarded $1,700 for services at hearing, to be paid by Consolidated Freightways. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by Consolidated Freightways.

NANCY A. DELOFF, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorney

WCB 81-7981
August 23, 1984
Order on Dismissal

The claimant has requested review of Referee's order dated July 13, 1984. The request for review was filed with the Board on August 15, 1984, more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The claimants request for review is hereby dismissed as being untimely filed.

LAURIE R. CLIFFORD, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-06230
August 29, 1984
Order on Reconsideration

The insurer requests clarification of the Board's Order on Review (Remanding) dated August 7, 1984.

The request is granted. At hearing, claimant sought an increase in her permanent disability award over the 10% granted by Determination Order. The Referee affirmed the Determination Order although he did not have the benefit of the pain center reports, which were to be made a part of the record but were not. On review claimant moved for remand for consideration of the pain center reports in evaluating her permanent disability. The Board agreed that the extent of claimant's disability could not be fully evaluated without consideration of the pain center records and ordered remand.

The insurer requests the Board "to clarify that its order is for the purpose of admitting the Pain Center records only, and not for the taking of further testimony or evidence." The Board so clarifies its order. The order of remand is not intended to open the door for proceedings other than the consideration of the pain center records and the reevaluation of claimant's permanent disability in light of those records.

ORDER

The Board's Order on Review (Remanding) dated August 7, 1984 is hereby republished as clarified above.

BILLY JOE JONES, Claimant
Royce, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 81-10929
August 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests, and the self-insured employer cross-requests, review of Referee Goss's orders which, in pertinent part: (1) awarded claimant an additional 80° for 25% unscheduled disability on review of Determination Orders entered upon termination/completion of an authorized program of vocational rehabilitation, ORS 656.268(5), thereby granting claimant a total unscheduled award of 208° for 65% permanent partial disability for injury to his low back; (2) declined to modify the September 28, 1982 Determination Order by awarding additional temporary total disability through and including September 3, 1982; (3) set aside the employer's denial of claimant's January 1983 aggravation claim; and (4) imposed a penalty and associated attorney's fee, apparently based upon the conclusion that the employer's aggravation claim denial was unreasonable. Claimant contends that he is entitled to an award for permanent total disability; or, in the alternative, an additional award of permanent partial disability and temporary total disability. The employer contends that claimant is entitled to no permanent disability in addition to the 128° for 40% unscheduled award previously granted; and that the Referee's findings and conclusions concerning claimant's 1983 aggravation claim, and the related penalty/attorney fee issues, are erroneous.

I

On the issue of extent of permanent disability, we substantially agree with the Referee's findings and conclusions. We find that claimant has failed to establish his entitlement to an award for permanent total disability on the basis of medical factors alone. Considering claimant's moderate physical impairment and the relevant social vocational factors leads to the conclusion that claimant has sustained a significant loss of earning capacity as a result of this industrial injury; however, we share some of the Referee's concerns with regard to claimant's motivation to engage in regular, gainful employment. We do not believe that claimant suffers a "severe" motivational deficit, as suggested by the Referee's order; however, our de novo review of the record fails to satisfy us that claimant is willing to seek regular, gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3). Nor are we able to conclude that claimant is so severely disabled as to be excused from this statutory requirement.

In determining the appropriate permanent partial disability award, we have considered the fact that in early 1980 claimant was adjudged to have a 40% unscheduled disability. There is little evidence to substantiate the Referee's conclusion that claimant's physical condition has worsened since the February 1980 Referee's order which awarded claimant this unscheduled disability. Claimant suffers from a degenerative condition of the spine diagnosed as lumbar spondylosis; however, objective findings, as identified by a 1982 lumbar myelogram, have remained unchanged since 1977. Symptomatically claimant appears to have worsened; however, it is well documented that claimant's subjective

complaints tend to be disproportionate to objective findings. Comparing the complaints expressed by claimant at the time of the extent litigation in 1980, with claimant's current complaints, it is difficult to discern a significant degree of difference. We conclude that claimant's medical conditon is essentially the same now as it was at the time of the 1980 Referee's order, by the terms of which claimant received an award for 40% unscheduled disability.

This does not end the inquiry, however. In Fred Hanna, 34 Van Natta 1271 (1982), the claim had been reopened for vocational rehabilitation and reclosed pursuant to ORS 656.268(5). In a prior proceeding, claimant had contended that he was permanently and totally disabled, but a Referee had awarded 50% permanent partial disability. On reclosure of the claim after completion of the vocational rehabilitation program, claimant again argued that he was permanently and totally disabled. We compared the circumstances existing at the time of the prior proceeding, which resulted in the Referee's award of 50% permanent partial disability, with the circumstances existing at the time of the proceeding on reclosure of the claim; and we concluded that the evidence failed to establish any changed circumstances in the interim. Thus we concluded that claimant was not entitled to any permanent disability in addition to the previously awarded 50% permanent partial disability. 34 Van Natta at 1277.

On review the Court of Appeals rejected our reasoning and stated:

> "ORS 656.268(5) provides that a new determination be made when a worker ceases to be enrolled in a program of vocational rehabilitation. The new determination would necessarily be based on the medical and other evidence available at that time, including that concerning the success or failure of the vocational rehabilitation program. A claimant's disability may be determined to be more or less than previously supposed after vocational rehabilitation, even absent a change in his medical condition. A change in a claimant's condition is not required to obtain a redetermination of extent of disability on termination of a program of vocational rehabilitation." Hanna v. SAIF, 65 Or App 649, 652 (1983) (footnote omitted).

On reclosure of a claim pursuant to ORS 656.268(5) we evaluate the claimant's unscheduled disability based upon presently existing facts and circumstances, but we take into consideration prior awards or prior adjudications of unscheduled disability as part of the evaluation process.

Although we find that claimant's medical condition is essentially the same now as it was at the time of the 1980 extent litigation, the events that have occurred since that time, including claimant's participation in an authorized program of vocational rehabilitation, indicate that claimant's disability is greater than that reflected by the 40% unscheduled award.

Claimant participated in a retraining program intended to establish him in a field related to auto mechanics, the emphasis being on auto electric with alternator and generator repair bench work. Claimant experienced an exacerbation of his injury-related condition during on the job training, and his physician ultimately expressed the opinion that this type of employment was beyond claimant's physical capabilities. Thus efforts to retrain claimant for a suitable occupation failed, in part, as a result of claimant's physical limitations. Of course, the record is replete with indications that claimant's retraining program failed, in significant measure, as a result of insufficient effort on his part. Also relevant, as noted by the Referee, is the fact that since the award of 40% unscheduled disability in 1980, it has become even more evident that claimant is foreclosed from returning to his previous occupation as a truck driver.

Considering all of the pertinent factors, including claimant's moderate physical impairment, his age (44), the fact that claimant is functionally illiterate despite his formal tenth grade education and GED, his employment history as a truck driver and construction laborer, his residual functional capacity for light work only, and his low-average to dull-normal mental capacity, we find that the Referee's increased award appropriately and adequately compensates claimant for the loss of earning capacity attributable to this industrial injury.

II

The other issues of substance are those related to claimant's January 1980 aggravation claim, including the issue of penalties and attorney fees.

On or about January 23, 1983, claimant was assisting an old acquaintance, George Player, who owns and operates a trucking business. Claimant experienced an acute exacerbation of his chronic low back pain as a result of his activities with Mr. Player on the day in question. The significant physical activity on claimant's part consisted of lifting and throwing wooden pallets out of Mr. Player's van. Each pallet weighed approximately 45 pounds. Claimant presented himself at the emergency room on January 23, 1983 and was hospitalized for conservative management of his low back pain. He was discharged on February 4, 1983.

The employer was advised of claimant's hospitalization and by denial dated February 3, 1983, informed claimant that it denied responsibility for claimant's apparently worsened condition. The basis of the denial was that claimant had sustained a new injury while working in the employ of George Player, relieving Boise Cascade Corporation of further responsibility for claimant's disability. At the hearing, the employer interposed a second argument in defense of its denial, see Robert G. Irvin, 35 Van Natta 1363 (1983), contending that in the event it was not relieved of responsibility for claimant's condition on the basis of a new injury, then there was insufficient evidence of a worsened condition to warrant claim reopening pursuant to ORS 656.273.

The Referee concluded that there was insufficient evidence of an employer-employe relationship existing between claimant and Mr.

Player at the time of claimant's injury. We are in complete agreement with this finding and affirm and adopt the relevant portions of the Referee's order. We disagree with the Referee's conclusion that claim reopening is appropriate, because on our de novo review of the record, we agree with the employer's contention that the evidence fails to substantiate a worsened condition warranting claim reopening.

Claimant is significantly disabled, as reflected by the award of 65% unscheduled disability. Claimant has been medically restricted for quite some time now with regard to his ability to lift in excess of 30 pounds. In addition, physicians have indicated that repetitive bending is contraindicated. Thus claimant is restricted to pursuing work of a light nature. Claimant experiences exacerbations and remissions of back pain characteristic of individuals suffering from chronic pain. It is clear that, as a result of claimant's excessive physical activity in January 1983 there has been no worsening of his underlying condition, i.e., the underlying degenerative process, and that claimant was hospitalized because of a symptomatic worsening of his chronic low back condition.

The employer argues that in the absence of evidence indicating that claimant's underlying condition has worsened, the claim should not be reopened pursuant to ORS 656.273. In James W. Foushee, 36 Van Natta 901 (1984), we found that a symptomatic worsening of claimant's low back condition was sufficient to warrant claim reopening pursuant to ORS 656.273. We based our Foushee decision, in part, upon the Supreme Court's recent decision in Garbutt v. SAIF, 297 Or 148 (1984), in which the court stated:

> "We allowed review in this case to make clear that a physician's report is not indispensable in a workers' compensation claim. In the case of an 'extent of disability' claim, such as this claim, as in the case of an aggravation claim, no physician's report is required to be statutorily sufficient. The worker's or other lay testimony may or may not carry the worker's burden of proving the extent of disability, but the law does not mandate a medical report. The same is true for an aggravation claim." 297 Or at 151-52.

The day after we decided Foushee, the Court of Appeals decided Scheidemantel v. SAIF, 68 Or App 822 (1984). The court affirmed that portion of our order which had upheld a denial of claimant's aggravation claim. In so holding, the court stated, "Claimant has the burden to show through medical evidence a worsening of her underlying condition, not merely an aggravation of her symptoms." 68 Or App at 826.

In Foushee we did not state a rule applicable to all claims for reopening under the aggravation statute. Rather, we held that "a symptomatic worsening may be sufficient to establish an aggravation claim," and in that case it was. 36 Van Natta at 904. It is difficult to ascertain whether the court in

Scheidemantel intended to state a rule of law applicable in all claims for reopening under ORS 656.273, or whether the court was merely stating a factual predicate to a finding of compensability in that claim. Considering the nature of the claimant's condition in Scheidemantel, we tend to believe that the court was stating the factual basis of its decision on de novo review, as opposed to stating a rule of law. This interpretation of the court's statement appears consistent with the implications of Garbutt v. SAIF, supra, as well as the policy expressed in our Foushee decision.

The following evidence is relevant to the issues concerning claimant's aggravation claim. When claimant was hospitalized in January of 1983, he was examined by Dr. Mason, a neurosurgeon who had become familiar with claimant's medical problem beginning in October of 1982. Dr. Mason had hospitalized claimant in December of 1982 for diagnostic purposes. When he examined claimant at the time of the January 1983 exacerbation and consequent hospitalization, he commented that claimant was being readmitted for recurring lumbar discomfort. He saw no cause to perform any diagnostic procedures in addition to the preceding December myelography. Dr. Mason's January 24, 1983 consultation report states, "I do not think that anything other than being off his feet for a period of time would be indicated at this point." Dr. Mason's deposition was taken after claimant's discharge from the hospital, and he testified that claimant had been hospitalized as a result of the marked increase in pain, which was secondary to claimant's overactivity.

Dr. Mason also testified:

> "[Claimant] has a chronic underlying back situation that is not going to change under the best of circumstances, and it is such that in itself it would not require hospitalization. But I think if he has an aggravation of his back pain, it can be severe enough and that's what happened in January to require a hospitalization and treatment. It's not likely that the treatment will ever be surgical, but it is medical treatment."

The deposition of Dr. Eisendorf also was taken in February 1983. Dr. Eisendorf has been treating claimant since 1967, and it was he who referred claimant for an evaluation by Dr. Mason in October of 1982. Although Dr. Eisendorf's deposition, as well as Dr. Mason's, was obviously taken in an effort to further the employer's defense of a new, independently contributory industrial injury in January of 1983, much of the testimony is elucidating with regard to the January symptomatic worsening of claimant's chronic back condition vis-a-vis the question of claim reopening pursuant to ORS 656.273. Dr. Eisendorf testified that the January 1983 incident was part and parcel of claimant's ongoing medical problem. The following question was asked and answered:

> "Q: Dr., would you expect that that two-week hospitalization was within the range of consequences of his exceeding the restrictions of the chronic ongoing problem that existed before that incident?

"A: I think that would be reasonable."

In some cases, such as Foushee, a symptomatic worsening will be found sufficient to warrant claim reopening under the aggravation statute. In other instances, it will not, as where the claimant has a history of a chronic pain problem characterized by periodic exacerbations and remissions. As we stated in Kenneth L. Elliott, 36 Van Natta 1141 (1984), in which we found that claimant failed to establish a worsening sufficient for purposes of reopening pursuant to the aggravation statute:

> "We do not find it noteworthy that a claimant with 45% permanent low back disability experiences flareups of symptoms. According to claimant's history, periods of more acute and less acute symptoms have arisen in the past and, it is safe to assume, will continue to occur periodically. Such a 'waxing and waning' is to be expected and does not require the reopening of a claim." 36 Van Natta at 1143.

The respective situations in Foushee and Elliott may be viewed as being more or less on opposite ends of a continuum. Depending upon where a particular case falls on the continuum, claim reopening pursuant to the aggravation statute may or may not be warranted. The fact that a claimant has been hospitalized does not, in and of itself, establish a worsened condition within the meaning of ORS 656.273. Van M. Brown, 36 Van Natta 1109 (1984); see Hutchinson v. Louisana-Pacific, 67 Or App 577 (1984).

Considering the evidence bearing upon claimant's symptomatic worsening in January of 1982, in light of all of the evidence relative to the nature and extent of claimant's chronic back condition, we conclude that claimant's symptomatic worsening and ensuing hospitalization in January of 1983 is consistent with the award of 65% unscheduled disability, that it represents one in a series of exacerbations which are characteristic of claimant's chronic pain syndrome, and that, in this particular case, claim reopening for payment of additional temporary total disability was not warranted.

In view of our conclusion concerning the compensability of claimant's aggravation claim, the Referee's imposition of a penalty and attorney's fee cannot be sustained. The aggravation claim arose on or about January 23, 1983. The employer apparently was notified quite promptly. As indicated, the employer denied the aggravation claim on February 3, 1983. This denial, obviously, was within 14 days of notice or knowledge of the claim, as it was within 14 days of the incident itself. By issuing its denial so promptly, the employer cut off its obligation to pay interim compensation. See ORS 656.273(6), 656.262(4). Since there was no obligation to pay interim compensation, and since we have found that the aggravation claim is not compensable, there are no amounts "then due" to form the basis for imposition of a penalty; and with the penalty, the associated attorney's fee fails. Darrell W. Carr, 36 Van Natta 16 (1984).

III

The remaining issue is raised by claimant's contention that the September 28, 1982 Determination Order erroneously terminated temporary disability benefits as of August 18, 1982. Claimant contends that no statement of his medically stationary status was forthcoming until Dr. Thompson's September 3, 1982 concurrence with the findings and conclusions of the pain clinic staff.

We conclude that claimant was medically stationary on August 18, 1982 based upon an office note of that date from Dr. Thompson. According to this office note, claimant apparently experienced an exacerbation of his back and left leg pain on Monday, August 16, while he was riding a stationary bicycle. Two days later Dr. Thompson examined claimant and found that his condition was "basically unchanged from previous examinations." Dr. Thompson concluded, "He was advised that I did not feel there was any significant change in his symptoms or findings but this was related to his previous set of symptoms. He is to return to the pain clinic and return here p.r.n."

It was apparently on the basis of this office note that the Evaluation Division determined that claimant was medically stationary on August 18, 1982. We agree with this determination and, therefore, decline to modify the Determination Order as requested. The pertinent portion of the Referee's order is affirmed.

ORDER

The Referee's orders dated April 25, 1983 and May 4, 1983 are reversed in part and affirmed in part. Those portions which set aside the employer's February 3, 1983 aggravation claim denial and imposed penalties and attorney fees are reversed; the employer's denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

DWAYNE A. KESTER, Claimant
Velure & Bruce, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 82-07338
August 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Brown's order which affirmed the September 30, 1982 Determination Order, wherein no additional permanent disability was awarded, and found that claimant had not proven an aggravation of his condition. Claimant contends that he is permanently and totally disabled and that his April 1981 aggravation claim is compensable. We reverse the Referee and award claimant permanent total disability.

We make the following findings of fact. Claimant is a 51 year old log truck driver who suffered a compensable injury in August 1977 when his truck left the road and overturned. He sustained significant head injuries which resulted in binaural hearing loss, balance difficulties, impairment of thinking processes, memory loss, slow slurred speech and left-sided hemiparesis. Claimant also developed shoulder, low back and leg pain as a result of the accident.

In August 1980 a Determination Order awarded claimant 40% unscheduled permanent disability for injury to his head, 40.38% scheduled disability for loss of hearing in his right ear and 38.5% scheduled disability for loss of hearing in his left ear. This award was eventually increased to 65% unscheduled disability by a Referee after a hearing in April 1981 and then to 75% by the Board.

In October 1980 the Southern Oregon Medical Consultants examined claimant and stated:

> "This patient should be encouraged to function within his limitations and to avoid those things that could cause further injuries to himself or others including hunting, driving, working around any type of moving equipment which requires balance and the ability to move quickly. Both his coordination and thought processes are significantly slowed from his post-traumatic encephalopathy. It would be much better to place the patient within a protected work situation with a very understanding employer, primarily requiring sitting and functioning of his right arm without the need for making frequent decisions or at least not under the stress of doing this rapidly."

From February 1978 until May 1981 claimant participated with various counselors in vocational rehabilitation efforts, including involvement in two sheltered workshops. Claimant's involvement with the second workshop, Klamath Work Activity Center, began in March 1981. In April 1981, nine days after claimant's hearing on extent of permanent disability, Dr. Kearns reported that claimant's back and leg pain had increased since working at the rehabilitation center. On May 11, 1981 claimant's vocational program was terminated due to his back pain.

Thereafter, the vocational consultants who arranged for claimant's participation in the Klamath sheltered workshop recommended that claimant's file be closed because they were the third private rehabilitation firm that had tried unsuccessfully to return claimant to a reliable job, claimant's GATB scores were in the lower average range with his finger and manual dexterity being in the bottom 10%, and claimant only qualified for two out of 68 occupational profiles. The combination of his physical limitations, education and age severely limited the jobs that were available to claimant, and since claimant dropped out of the sheltered workshop setting, they had no viable jobs that they could offer claimant and believed that further efforts on their part would not be fruitful. Intelligence testing shows claimant to now be in the dull-normal range. A September 30, 1982 Determination Order closed the claim following termination of the vocational program.

In April 1983 Dr. Dunn reported that claimant's back pain was exacerbated by lifting, bending, twisting, or any type of increased motion. He also reported limited range of motion in claimant's low back. In June 1983 Dr. Dunn indicated that

claimant was limited to sitting two hours, standing two hours and walking two hours total in an eight hour day. Claimant could occasionally lift, carry and push up to 20 pounds and should never bend or twist.

Claimant's job seeking efforts since his experience at the Klamath Center consisted of applying for a job as a salesperson at a fireplace store and checking the classified advertisements in the newspaper.

The Referee found no change in claimant's condition since the April 1981 hearing on extent of disability and, therefore, that claimant could not have his permanent disability redetermined. Since the Referee's order, however, the Court of Appeals decided Hanna v. SAIF, 65 Or App 649 (1983), which states, "A change in a claimant's condition is not required to obtain a redetermination of extent of disability on termination of a program of vocational rehabilitation." 65 Or App at 652. See Billy Joe Jones, 36 Van Natta 1230 (decided this date).

First, based on Dr. Kearns' April 30, 1981 report we find that claimant's condition worsened after the April 1981 hearing as a result of participating in the sheltered workshop and that his aggravation claim thus is compensable. Dr. Kearns recommended that claimant be off work for another week and that he could return to work thereafter providing he significantly improved. Claimant did not return to the Klamath Center. The September 30, 1982 Determination Order, as amended by a March 11, 1983 Determination Order, awarded temporary disability through May 11, 1981. Since no time loss was authorized beyond this date, no additional time loss is due under the aggravation claim.

Second, even if we did not find the aggravation claim compensable, we would rate claimant's permanent disability without regard to whether his condition has changed. Hanna, supra. We consider claimant's severe impairment including disabling pain, his age of 51, his education consisting of a GED, his intelligence level, and his work experience as a log truck driver, ranch hand, mill worker and carpenter. We also consider claimant's vocational efforts and the conclusions of the vocational consultants regarding claimant's employability. We find that claimant has made reasonable efforts to obtain employment under ORS 656.206(3). Furthermore, we conclude that claimant is permanently totally disabled beginning May 12, 1981, the day after his last vocational program was terminated due to his worsened condition.

ORDER

The Referee's order dated November 2, 1983 is reversed. Claimant is awarded permanent total disability as of May 12, 1981. Claimant's attorney is awarded 25% of claimant's compensation as an attorney fee, said sum to be paid out of claimant's compensation.

FORREST A. LAFFIN, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-01857
August 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Braverman's order which assessed an attorney fee against it for claimant's prevailing on the issue of eligibility for a vocational rehabilitation program. The Field Services Division cross-requests review alleging that claimant failed to exhaust his administrative remedies and, alternatively, that on the merits he is not eligible for a vocational rehabilitation program. Claimant also filed a cross request for review, however we are unable to determine what issue claimant intended to raise by his cross request for review.

Claimant sought FSD approval for an out of state vocational rehabilitation program. FSD refused approval on January 15, 1982 stating, "You are not available for services because: you are residing out of state." On March 19, 1982 claimant filed a supplemental request for hearing raising the issue of FSD's refusal to authorize the vocational rehabilitation program.

At hearing, the insurer's attorney declined to represent FSD despite OAR 436-61-970(1), which became effective prior to the hearing. The regulation provides:

> "Insurers are responsible for defending issues involving expenditure of Rehabilitation Reserve Funds whenever vocational assistance is an issue for hearing or litigation. This section applies whether worker vocational assistance is the responsibility of the insurer or the Division."

The Referee held that claimant is eligible for the vocational rehabilitation program and assessed an attorney fee against the insurer. The insurer requested reconsideration asking the Referee to clarify that the insurer did not represent FSD at hearing and asking that the Referee not assess the attorney fee against it because it had not taken a position adverse to the claimant at hearing. The Referee clarified that the insurer's attorney had never represented FSD at hearing, nevertheless, he held that the attorney fee was properly assessed against the insurer.

The insurer requested review on the attorney fee issue. FSD, through the Attorney General, cross-requested review. In its brief on review, the Attorney General anticipates the argument that it waived appearance at hearing and is, therefore, barred from entering the case on Board review.

The Board has refused to allow the Attorney General's office to enter a case at the Board level where we found that the Attorney General's office had waived appearance. Gary R. Rapp, 34 Van Natta 1236 (1982). However, we agree with the Attorney General that a waiver requires an intentional relinquishment of a known right. Under the circumstances of this case, we find that the Attorney General's office did not waive appearance because it

believed the insurer would represent FSD's interests pursuant to OAR 436-61-970(1). It was only after the hearing that the Attorney General's office learned that the insurer's attorney did not represent FSD's interest. Accordingly, we find that the Attorney General's office did not knowingly waive appearance before the Referee and that it properly represents FSD before the Board.

On the merits, we find that claimant failed to exhaust his administrative remedies. At the time claimant requested a hearing on FSD's refusal to authorize claimant's vocational rehabilitation program, OAR 436-61-998 required claimant to first seek administrative review with the Director of the Workers' Compensation Department before requesting a hearing on an eligibility issue. We have previously held that OAR 436-61-998 is to be applied retroactively. Dan M. Miller, 36 Van Natta 245 (1984). Accordingly, we find that claimant has failed to exhaust his administrative remedies and the claim is not properly before the Board. As we did in Miller, we refer the matter to the Director for review of FSD's decision.

Because of our disposition of this case, the attorney fee issue is moot.

ORDER

The Referee's orders dated August 31, 1983 and September 28, 1983 are vacated, claimant's request for hearing on the eligibility issue is dismissed and the matter is referred to the Director of the Workers' Compensation Department pursuant to ORS 656.728(6) and the applicable administrative rules.

JIMMIE PARKERSON, Claimant
Gatti & Gatti, Claimant's Attorneys
Donald Howe, Asst. Attorney General
Lindsay, et al., Defense Attorneys

WCB 82-07754, 82-07755, 82-07756 & 82-11210
August 29, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

EBI Companies, the insurer for Salem Tent & Awning, requests review of those portions of Referee Nichols' orders which set aside EBI's denial of claimant's August 17, 1982 new injury claim. The Inmate Injury Fund (hereinafter "Fund") cross-requests review of those portions of the Referee's orders which awarded claimant 32° for 10% unscheduled disability in connection with claimant's July 22, 1981 injury and ordered that the Fund pay claimant and his attorney a penalty and associated attorney's fee for the Fund's failure to properly process claimant's aggravation claim. The Fund's cross-request for review was dismissed on claimant's motion for the reason that it was not timely filed. Jimmie Parkerson, 35 Van Natta 1247 (1983). Because the Fund has argued these points in its respondent's brief, we have considered the issues as being properly before us on review. Id. at 1249-50.

On the responsibility issue raised by EBI, we reverse. In concluding that claimant's August 17, 1982 incident represented a new injury rather than an aggravation of one of claimant's earlier injuries insured by the Fund, the Referee relied upon the facts that claimant experienced the sudden, immediate onset of low back pain when he squatted while unloading pipe; that, prior to this

incident, claimant had been working for a few weeks performing relatively heavy labor; and claimant's testimony concerning his belief that his low back condition, as of the time of hearing, had not returned to its pre-injury (August 17, 1982) level.

In reaching the opposite conclusion, we are persuaded by the following facts. Claimant had been examined by Dr. Spady approximately three weeks before the August 1982 incident, at which time Dr. Spady diagnosed a sprain of the lumbar spine region, from which claimant had "essentially recovered . . . with some minor residual symptoms which require caution in his work activities." Claimant had given a history of occasional symptoms during his work activity as an awning installer at that time, with continuing mild low back discomfort and increased pain caused by bending and lifting. The incident which caused the onset of claimant's August 17, 1982 episode, although it occurred during a period of work activity, was not, in and of itself, one which we believe can be fairly characterized as a "traumatic injury"; rather, claimant was in the process of laying a piece of pipe on the ground, and he was in a squatting position, when he experienced the episode in question. This inciting event was more in the nature of a simple movement, as opposed to a trauma.

Considering the findings of Dr. Spady's examination, the fact that three weeks later claimant experienced this episode which appears entirely consistent with Dr. Spady's prognostication, the intervening period of continuing symptoms and the nature of the incident in question, we are inclined to believe that claimant's August 1982 episode is more in the nature of an aggravation of his prior low back injuries as opposed to a new, independent injury for which EBI bears responsibility. Although this is a typically close responsibility question, we believe that, on the aggravation/new injury continuum, it is closer to that end of the spectrum which Professor Larson describes as including:

> ". . . the kind of case in which a man has suffered a back strain, followed by a period of work with continuing symptoms indicating that the original condition persists, and culminating in a second period of disability precipitated by some lift or exertion." 4 Larson, Workmen's Compensation Law § 95.23, at 17-135 (1984).

These circumstantial factors, coupled with the apparently unanimous medical opinion that claimant's August 17, 1982 episode represents an exacerbation or continuation of his previous low back problems, persuade us that claimant sustained an aggravation rather than a new injury. This makes it necessary to identify which one of claimant's three accepted injury claims processed by the Fund should be held accountable for claimant's low back condition on and after August 17, 1982; i.e., under which one of the three injury claims the Fund should process this aggravation claim. We believe the record establishes that the third of claimant's three accepted injuries (that date of injury being July 22, 1981) was the most severe of these three injuries and accountable for the most significant portion of the residual impairment claimant continued to experience, which ultimately led to the August 1982 exacerbation. Accordingly, we order the Fund to process this claim as an aggravation of claimant's July 22, 1981 injury.

Our finding that the Fund is responsible to pay claimant's compensation in connection with an aggravation of his July 1981 injury obviates the need to address the issues raised concerning the proper evaluation and extent of claimant's permanent disability. When claimant's condition is once again determined to be medically stationary, the Fund will be required to reclose claimant's July 22, 1981 claim, at which time claimant will be entitled to a new determination concerning permanent disability, if any, as well as a hearing pursuant to ORS 656.283.

On the issue raised by the Fund, concerning the Referee's imposition of a penalty and attorney's fee, we reverse. The record does not support the Referee's conclusion that the Fund was required to pay interim compensation because it contains no evidence that the Fund had the requisite notice or knowledge of claimant's medically verified inability to work due to a worsening of his injury-related condition. ORS 656.273(6). Although the Fund might otherwise be subject to a penalty for its failure to respond to claimant's aggravation claim, we assess no penalties because no amounts were "then due" upon which to assess penalties. ORS 656.262(10); see EBI v. Thomas, 66 Or App 105 (1983); see also Darrell Carr, 36 Van Natta 16 (1984).

ORDER

The Referee's orders dated April 29, 1983 and May 9, 1983 are reversed in part, vacated in part and affirmed in part. Those portions of the orders which set aside EBI's denial of claimant's new injury claim are reversed, and EBI's denial dated December 1, 1982 is reinstated and affirmed. This claim is remanded to the Inmate Injury Fund for acceptance and processing as an aggravation of claimant's July 22, 1981 injury claim. Those portions of the Referee's order which imposed a penalty and associated attorney's fee for the Inmate Injury Fund's failure to pay interim compensation and timely accept or deny claimant's aggravation claim are reversed. The Referee's award of 32° for 10% unscheduled permanent disability in connection with claimant's July 22, 1981 low back injury is vacated. The remainder of the Referee's order is affirmed. Compensation and attorney fees paid or payable by EBI under the terms of the Referee's order shall be reimbursed to EBI and paid by the Inmate Injury Fund.

JACK R. STEIMER, Claimant
Evohl Malagon, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 81-08623
August 29, 1984
Order on Remand (Remanding)

This case is presently before us on remand from the Court of Appeals. Steimer v. Boise Cascade Corp., 67 Or App 11 (1984). The issue is whether this case has been "improperly, incompletely or otherwise insufficiently developed or heard by the Referee" within the meaning of ORS 656.295(5); and, if so, whether it should be remanded to the Referee for further evidence taking. See Bailey v. SAIF, 296 Or 41, 44 (1983).

Claimant was unrepresented at hearing. The issue was the extent of permanent partial disability, if any, resulting from his industrial injury, the most apparent and direct result of which was the loss of a testicle. The Referee concluded that there was no evidence to support a finding that claimant's earning capacity

had been impaired or adversely affected by his injury. On review we denied claimant's request for remand and affirmed the Referee's order, finding "no basis in Oregon law to make an award of permanent disability." 35 Van Natta 565, 566 (1983).

After we issued our Order on Review, the Supreme Court decided Bailey v. SAIF, supra, in which the court stated, among other things:

> "It must be remembered that we are considering the actions of an administrative board designed to be flexible in its search for accurate facts and just conclusions. The formal rules of evidence designed for trials are relaxed. Decisions on compensability may be reopened to develop completely the record with much greater ease than judgments in civil cases where one of the parties wishes to set aside, for example, a judgment for newly discovered evidence." 296 Or at 46.

Whether the issue is compensability or extent of disability, the same considerations concerning the "search for accurate facts and just conclusions" apply. See, e.g., Egge v. Nu-Steel, 57 Or App 327 (1982).

The few documents admitted as exhibits at the hearing indicate that, as a result of the direct trauma to claimant's groin, he may have sustained an injury to his low back. Claimant testified that he continued to experience problems with regard to the condition of his back. Claimant was represented by counsel on Board review, and a report of a psychiatric evaluation (conducted after issuance of the Referee's order) identified, among other things, an adjustment disorder with work inhibition, which was initially severe following claimant's injury. This physician stated his uncertainty as to whether this disorder was resolving or whether it might form the basis for the development of a chronic post-trauma stress syndrome with cueing at some later date.

As of the time of hearing, claimant has become reemployed as a salesman. The record is not developed concerning his reasons for terminating his employment of two and a half years with Boise Cascade (the employer herein); however, the report submitted in support of remand suggests claimant's belief that there were "hard feelings," and that this played a role in his return to retail sales work. When asked by the Referee whether he had any trouble performing his present job, he stated that he did with respect to his back condition. Claimant stated, on more than one occasion, that he was "able to work, by law."

If claimant is entitled to any award for permanent disability, it is for an unscheduled disability. The criterion for rating unscheduled disability is the permanent loss of earning capacity due to a compensable injury. "Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, training, skills and work experience." ORS 656.214(5).

It is all too evident that claimant has no conception of the meaning of lost earning capacity. It was obviously his

understanding that, because he was presently gainfully employed, he could not "by law" receive an award for permanent disability. It is also painfully apparent that claimant sought to utilize the hearing before this Referee as a forum to air his heartfelt belief that his injury, as well as injuries sustained by coworkers, resulted from the employer's failure to implement precautionary safety measures.

Although claimant chose to proceed with the hearing without the assistance of counsel, the record clearly reflects that he had little or no understanding of the nature of the proceeding. As a result, the record, to the extent that it was developed at all, was incompletely and insufficiently developed on the issue of unscheduled permanent disability.

Considering the peculiar circumstances presented herein, and based upon our conclusion that the record has been incompletely and insufficiently developed, we conclude that it is appropriate to remand this matter to the Hearings Division for further proceedings on the issue of claimant's unscheduled permanent disability, if any.

ORDER

This case is remanded to the Hearings Division for further proceedings consistent with this order.

WILLIAM A. WALKER, Claimant
Myrick, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-11426
August 29, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Mongrain's order which set aside its denial of continuing responsibility for treatment of claimant's psychological condition, variously diagnosed as post-concussion syndrome, post-traumatic stress disorder and, most recently, schizo-type personality disorder. The issue is compensability. In addition, SAIF has moved the Board for an order remanding to the Referee for further evidence taking. See 656.295(5).

SAIF's motion for remand is denied. The additional evidentiary material submitted in support of SAIF's motion (which has been considered solely for the purpose of ruling on the motion) does not support the conclusion that the record has been improperly, incompletely or otherwise insufficiently developed on the critical issue, i.e., the causal relationship between claimant's January 1981 industrial injury and his ongoing psychological disorder. Indeed, the proffered evidentiary material tends to support the conclusion reached by the Referee, indicating that the record has not been inadequately developed on the causation issue.

On our de novo review of the record, as defined by ORS 656.295(5), we find that a preponderance of the evidence identifies claimant's ongoing psychological disorder as a compensable consequence of his industrial injury. We are in agreement with the Referee's analysis and conclusions; therefore, we affirm and adopt his well-reasoned order.

ORDER

The Referee's order dated August 23, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

SHARON BRACKE, Claimant
Parker & McCann, Claimant's Attorneys
Cheney & Kelley, Defense Attorneys

WCB 83-02130
August 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Neal's order which: (1) awarded claimant temporary total or temporary partial disability from July 1, 1977 until claimant's claim is closed pursuant to ORS 656.268; and (2) awarded penalties of 25% of the amounts due claimant until the date of hearing, and attorney fees, for the insurer's refusal to pay temporary disability benefits. The insurer contends that the period of temporary disability ordered is excessive and that the penalties and attorney fees are unwarranted.

The Board modifies the Referee's award of temporary disability, penalties and attorney fees.

We make the following findings of fact. Claimant suffers from a pulmonary disease, "meat wrappers' asthma," which was found to be a compensable occupational disease and the responsibility of Baza'r and its insurer, New Hampshire Insurance Co. Bracke v. Baza'r, 293 Or 239 (1982). Claimant worked as a meat wrapper for Baza'r until March 30, 1977. She also worked part-time as a meat wrapper for Albertson's and Thriftway, her last day with Albertson's being May 9, 1977 and her last day with Thriftway being May 14, 1977. Claimant testified that she discontinued working as a meat wrapper in May 1977 because she was ill from meat wrappers' asthma. We accept claimant's testimony in this regard as we rely on the opinion of Dr. Bardana, who reported that claimant's work termination in May 1977 was medically indicated due to meat wrappers' asthma and that claimant was totally disabled from gainful employment for at least three months.

Dr. Bardana reported, based on claimant's history, that by August 1977 claimant still had significant reversible obstructive lung disease and remained about 50% disabled at that time. Further, Dr. Bardana opined that by December 1977 claimant was near total recovery and he assumed claimant's disability to be negligible with regard to many forms of sedentary work. Dr. Bardana reported that certainly by the time he first saw claimant on September 13, 1978 she was totally capable of gainful employment, providing there was no undue exertion and a reasonably pollutant-free environment, since she still had an element of reactive airway disease secondary to her work as a meatwrapper. When Dr. Bardana saw claimant on September 13, 1978, she was jogging three miles a day but required the use of a bronchodilator to remain asymptomatic.

Dr. Bardana stated that claimant has permanent residuals of meat wrappers' asthma in the form of the sensitivity she has acquired to thermoactivated PVC and price labels. Claimant's

bronchial spasm reaction also would be triggered by other irritants such as cigarette smoke. Dr. Bardana explained that once the sensitivity is acquired, the patient is permanently sensitized. He expected claimant to remain asymptomatic, as she was when he saw her in September 1978, unless she was in an environment with triggering agents.

Claimant filed a claim against Baza'r in January 1978, which was denied in March 1978. The Referee upheld Baza'r's denial and the Board affirmed the Referee's order. Sharon Bracke, 29 Van Natta 947 (1980). The Court of Appeals found Baza'r responsible for claimant's condition, but remanded to the Board to determine which insurer was responsible or whether Baza'r was self-insured at the time claimant contracted the disease. Bracke v. Baza'r, 51 Or App 627 (1981). The Supreme Court agreed that Baza'r was responsible but found that Baza'r was insured by New Hampshire Insurance Co. at the time claimant became disabled, so remand was not necessary. 293 Or 239 (1982).

Therefore, the case was not remanded to the insurer for acceptance until the Supreme Court's mandate issued on April 4, 1983. The insurer requested claim closure on April 12, 1983 and on April 20, 1983 the insurer paid claimant temporary total disability from March 30, 1977 through June 30, 1977.

Claimant never returned and was never released to return to her regular work as a meat wrapper.

On May 12, 1983 the Evaluation Division issued a Determination Order which awarded claimant temporary total disability from January 12, 1977 through March 30, 1977. Thereafter, Dr. Keppel, claimant's treating doctor, reported that claimant still had persistent reactive airway disease which required medical treatment of the symptoms. Dr. Keppel opined, therefore, that claimant has residuals from her original exposure as a meat wrapper. On July 14, 1983 the May 12, 1983 Determination Order was rescinded by the Evaluation Division on the grounds that claimant's condition had not become medically stationary.

Another Determination Order issued on August 25, 1983 awarding temporary total disability from January 12, 1977 through September 13, 1978. Subsequently, Dr. Keppel reported that claimant continued to require the use of a bronchodilator for the control of her symptoms. Dr. Keppel also stated that claimant had not been able to return to any gainful employment. By order dated November 3, 1983, the Evaluation Division rescinded the August 25, 1983 Determination Order, also on the grounds that claimant's condition had not become medically stationary. By the time of hearing, no other Determination Order had been issued and the insurer had paid claimant no temporary disability benefits other than the three months of benefits paid in April 1983.

Claimant testified that after she quit working as a meat wrapper in May 1977 she worked for two or three months as a waitress, but had to quit due to cigarette smoke irritation. Claimant testified that she then went on welfare and had no further employment until March 1980, when she worked at Healthways for two or three months. Then claimant said she worked at

Portland Public Schools from June to July 1980, at the Gourmet Rabbit from October to November 1980, at Gateway Gourmet in November 1980, and at Oregon Drapery from November 1980 to January 1981. In spring 1981 claimant began going to school at Portland Community College (Sylvania), where she also worked. At the time of hearing, claimant continued attending classes and working at the school.

The Referee held that once the insurer was obligated to pay time loss, it could not unilaterally terminate time loss unless claimant returned to her regular work as a meat wrapper, was released to return to her regular work or her claim was closed by the Evaluation Division. Accordingly, the Referee ordered the insurer to pay time loss benefits from July 1, 1977 until the claim is closed under ORS 656.268. The Referee did not decide and the parties did not raise the issue of claimant's medically stationary date, that is, whether the Evaluation Division was correct in rescinding the Determination Orders on the basis that claimant was not medically stationary.

This case presents the question of what benefits the insurer must pay on a claim that has been in denied status, once the insurer is ordered to accept the claim. Generally, the law requires an insurer to pay time loss until the claimant returns or is released to return to regular work, or a Determination Order issues terminating the duty to pay time loss. Jackson v. SAIF, 7 Or App 109 (1971); ORS 656.268. Therefore, if the claimant has not returned or been released to return to regular work, the insurer generally must pay time loss until the Determination Order issues under ORS 656.268 upon the claimant becoming medically stationary. In this case the claim had been in denied status and claimant had not returned or been released to return to regular work. If claimant became medically stationary before the claim was found compensable, however, a Determination Order would not have been issued when claimant became medically stationary since the claim was in denied status. Moreover, a Determination Order most likely would not have been issued within 14 days of the insurer being ordered to accept the claim. If the insurer, upon a finding that the claim is compensable, is required to pay time loss until a Determination Order issues even though the claimant has become medically stationary in the interim, the insurer could be required to pay more time loss upon remand for acceptance than it would have had to pay had it originally accepted the claim. Therefore, the question presented is, if the claimant has not returned or been released to return to regular work and the claim has been in denied status, is the insurer upon being ordered to accept the claim required to pay time loss until a Determination Order issues if the claimant has become medically stationary in the interim?

Before we address that question, however, we must decide whether claimant became medically stationary prior to the order to accept the claim. We address this question even though the issue was not addressed by the Referee or raised by the parties. Russel v. A & D Terminals, 50 Or App 27 (1981). But see Michael R. Petkovich, 34 Van Natta 98 (1982). Giving claimant the benefit of the doubt, we find that claimant was medically stationary when she was examined by Dr. Bardana on September 13, 1978. We find that any medical treatment claimant received or disability she suffered

after that date was a function of her permanently sensitized condition and should be considered in evaluating her permanent disability. Therefore, we hold that the Determination Orders dated July 14, 1983 and November 3, 1983, finding that claimant was not medically stationary, were in error.

Having found claimant medically stationary on September 13, 1978, we next examine the relevant case law.

In Clyde Hargens, 34 Van Natta 751 (1982), two years had elapsed from the date of the aggravation claim until the Board's order finding the aggravation claim to be compensable. The claimant was released to return to light work on February 2, 1981, long before the Board found the aggravation claim compensable. To require payment of time loss through the date of claim closure would have meant payment from May 1980 through June 1982. The Board deemed payment for such an extended period to be inequitable and ordered time loss to be paid until February 2, 1981, with the understanding that the Evaluation Division was to make an independent determination when it closed the claim under ORS 656.268.

Similarly, the Board stated in David Cheney, 35 Van Natta 109 (1983), that when a claim has been in denied status until a finding of compensability, to require the insurer to pay time loss until claim closure may result in payment of time loss which greatly exceeds the amount otherwise payable and which the insurer may not be able to recoup. Furthermore, in Frank Gonzales, 34 Van Natta 551 (1982), the Board stated that upon a finding that a claim is compensable, the insurer has the duty to ascertain and pay time loss. The claimant's entitlement to time loss continues until the claimant returns to work or becomes medically stationary.

With this case law in mind, the Board holds that, within 14 days of a litigation order finding a claim compensable the insurer shall pay the claimant time loss benefits, OAR 436-54-310(3)(e), until the date that claimant returned or was released to return to regular work or was declared (as opposed to being determined under ORS 656.268) to be medically stationary. If none of these events has occurred, the insurer shall continue time loss payments until termination is authorized under ORS 656.268 and Jackson v. SAIF, supra.

We recognize that this holding is a narrow exception to ORS 656.268 and Jackson v. SAIF, supra, and we emphasize that the insurer is allowed to so unilaterally terminate time loss only when ordered to accept a claim which has been in denied status. Upon an order to accept the claim, the insurer shall act quickly to determine whether claimant has become medically stationary, to pay the time loss to which the claimant is entitled and, if appropriate, to request claim closure under ORS 656.268. Upon claim closure the time loss period is subject to independent assessment by the Evaluation Division. If the insurer believes the claimant is medically stationary and requests claim closure, but the Evaluation Division refuses to close the claim because it finds the claimant is not medically stationary, the insurer can request a hearing on the medically stationary and claim closure issues. ORS 656.283. Under such a situation, however, the insurer is required to pay time loss on a continuing basis until

termination is authorized. In addition, the insurer would face imposition of penalties and attorney fees if its medically stationary/termination of time loss decision is found to have been unreasonable.

As found above, claimant never returned and was never released to return to her regular work. As also discussed above, claimant was medically stationary on September 13, 1978. When the claim was ordered accepted, therefore, the insurer should have paid time loss through the date that it decided that claimant was medically stationary and requested claim closure, which is essentially what the insurer did here. Although the medically stationary date and the time loss period generally would be subject to independent assessment by the Evaluation Division upon claim closure, our decision that the Evaluation Division erred in finding that claimant was not medically stationary and our determination of the time loss period precludes such independent assessment.

Therefore, we find that claimant was entitled to time loss from May 15, 1977 through September 13, 1978. We do not find any evidence that subsequent to the medically stationary date of September 13, 1978 claimant's condition worsened, entitling her to an additional period of time loss. We remand this claim to the Evaluation Division for issuance of a Determination Order stating the medically stationary date and time loss periods found above and determining the amount of permanent disability to which claimant is entitled.

Regarding penalties and attorney fees, we find that the insurer's failure to pay time loss benefits, beyond the three months of benefits paid, to have been unreasonable in light of the August 25, 1983 Determination Order which awarded claimant time loss from January 12, 1977 through September 13, 1978. The Determination Order ordered the insurer to pay those benefits and the insurer failed to do so. Therefore, we assess a penalty of 25% of the temporary total disability awarded by the August 25, 1983 Determination Order, less the three months of time loss already paid by the insurer.

ORDER

The Referee's order dated December 9, 1983 is modified. Claimant is found to be medically stationary on September 13, 1978. Claimant is awarded temporary disability from May 15, 1977 through September 13, 1978, less time worked. Claimant's attorney fees associated with this temporary disability award shall be adjusted accordingly. This matter is remanded to the Evaluation Division for determination of this claim under ORS 656.268, which shall include the medically stationary date and temporary disability period ordered above and which shall determine claimant's entitlement to an award of permanent disability. The insurer is ordered to pay a penalty of 25% of the temporary disability due claimant from January 12, 1977 through September 1978, less three months of temporary disability already paid, for its failure to pay the temporary disability awarded by Determination Order dated August 25, 1983, and an associated attorney fee of $1000.

DONALD G. MOORE, Claimant
Malagon & Associates, Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-09680
August 30, 1984
Order on Reconsideration

The SAIF Corporation requests reconsideration of our Order on Review dated February 28, 1984. 36 Van Natta 113 (1984). In order to allow an adequate opportunity to consider SAIF's request and claimant's response thereto, we abated our Order on Review. 36 Van Natta 398 (1984).

In November 1980 claimant sustained a compensable upper back and neck injury. In May 1981 the claim was closed by a Determination Order which awarded temporary disability only. Later in May 1981 claimant requested claim reopening, which was denied by SAIF in August 1981. SAIF's denial of claimant's aggravation claim was upheld by a Referee's order in October 1981.

In July 1982 claimant filed another request for hearing, again contending, among other things, that he was entitled to claim reopening on the basis of aggravation. In September 1982 the parties executed a Stipulated Order. SAIF agreed to pay claimant's reimbursable travel expenses in connection with medical treatment and an attorney fee. The stipulation does not specifically mention claimant's aggravation claim that was pending at the time of the stipulation, but it recites that claimant's "request for hearing (and all issues raised thereby, or which could have been raised thereby) be, and the same hereby is, dismissed with prejudice."

Later in September, about a week or two after the stipulation was executed, claimant was examined by Dr. Melson, who suggested that claimant's claim "should be reopened for further medical treatment." Claimant's attorney forwarded Dr. Melson's report to SAIF and requested that SAIF "promptly authorize the treatment requested by Dr. Melson." Responding to Dr. Melson's report and claimant's attorney's letter as yet another aggravation claim, SAIF issued a denial on November 3, 1982. Claimant requested a hearing on that denial, which gave rise to this proceeding.

The Referee set aside SAIF's denial, concluding in his initial order that the September 1982 stipulation could not have effectively disposed of claimant's then-pending and prior aggravation claim because that claim was not then in denied status. See Syphers v. K-W Logging, Inc., 51 Or App 769 (1981). As we noted in our prior Order on Review, that line of reasoning no longer appears to be viable in light of the court's subsequent refinement of Syphers in Thomas v. SAIF, 64 Or App 193 (1983).

The Referee's order on reconsideration reiterated his Syphers reasoning and also stated that the parties' September 1982 stipulation was not an award or arrangement of compensation within the meaning of ORS 656.273. In our prior Order on Review, we stated our agreement with the Referee's alternative rationale, based upon our decision in Lewis Twist, 34 Van Natta 52, 34 Van Natta 290 (1982), affirmed 62 Or App 602 (1983):

> "In Lewis Twist, supra, we concluded that a prior litigation order upholding a denial of an earlier aggravation claim was not the

> last award or arrangement of compensation within the meaning of ORS 656.273 when a claimant asserts a later aggravation claim. That reasoning is directly applicable in this case in the sense that the October 1981 Referee's order, which upheld a prior denial of a prior aggravation claim, is not the last award for present purposes. We also here conclude that Twist is applicable to the September 1982 stipulation in the sense that, even if that stipulation had expressly said that claimant's mid-1982 aggravation claim could and would properly be deemed denied, the stipulation can have no greater force or effect than a litigation order. Stated differently, if a prior litigation order that upholds an aggravation denial is not the last award of compensation, we think it follows that a prior stipulation that has the effect of upholding an aggravation denial likewise is not the last award of compensation." 36 Van Natta at 114.

We concluded that the last award or arrangement of compensation for purposes of claimant's September/October 1982 aggravation claim was the May 1981 Determination Order which originally closed this claim. We also concluded that claimant had proven a worsening of his condition since that time.

In Twist, in addition to holding that a litigation order upholding a denial of an aggravation claim does not constitute the last award or arrangement of compensation for purposes of a subsequent aggravation claim, we discussed some other aspects of the res judicata doctrine as it relates to successive aggravation claims. We stated:

> "There are certainly some situations in which the decision on an earlier aggravation claim would bar a subsequent aggravation claim. A claimant cannot present at a hearing on a second aggravation claim exactly the same evidence that was presented at an earlier hearing on a prior aggravation claim; in such a situation the result of the first hearing is res judicata. [Citation omitted.] Nor can a claimant present in a subsequent aggravation hearing evidence that was available or could have been obtained at the time of the first aggravation hearing." 34 Van Natta at 232.

In other words, if a denial of "aggravation claim number one" is upheld because the evidence indicates that the claimant's condition has not worsened since the last award of compensation, and the evidence in support of "aggravation claim number two" indicates that the claimant's condition at that time is the same as it was at the time of "aggravation claim number one," then

"aggravation claim number two" is barred by res judicata. Such a conclusion would be inescapable because, under these hypothesized circumstances, the two aggravation claims would be exactly the same "cause of action."

We think the same rationale applies when an earlier aggravation claim has been resolved by stipulation, and it remains in denied status. The claimant cannot successfully prosecute a later claim for aggravation where his or her condition is the same as it was at the time of the prior stipulation. If the claimant's condition is not the same, then the prior stipulation is not a bar.

As we stated in our prior Order on Review, we understand the effect of the parties' September 1982 stipulation to be that claimant was then agreeing that his mid-1982 aggravation claim could and would be deemed to be denied. See Thomas v. SAIF, supra. And, as previously stated above, this aggravation claim was asserted just a couple of weeks after the execution of that September 1982 stipulation.

Our review of the record on reconsideration discloses no evidence of any change or difference in claimant's condition during the weeks or months after the September 1982 stipulation, when compared with the evidence of his condition at or about the time of the September 1982 stipulation. Orthopaedic Consultants' findings on August 25, 1982 (i.e. before the stipulation) are essentially identical to Dr. Melson's findings on September 17, 1982 (i.e. after the stipulation). And claimant's testimony does not indicate any real change in his condition after the date of the stipulation; claimant relates his problems to an attempt to return to work in June 1982, which resulted in an exacerbation of his neck and mid-dorsal symptoms, which, of course, was before the September 1982 stipulation.

We conclude that claimant's current condition (i.e. as of the April 1983 hearing herein) is the same as his condition at the time of the September 1982 stipulation which, in effect, denied claim reopening at that time. Under these circumstances, the current aggravation claim is barred by operation of res judicata.

ORDER

On reconsideration, the Board's Order on Review dated February 28, 1984 is withdrawn.

On reconsideration, the Referee's orders dated May 19, 1983 and June 1, 1983 are reversed, and the SAIF Corporation's denial dated November 3, 1982 is reinstated and affirmed.

JANIS F. NETLAND, Claimant
Pozzi, et al., Claimant's Attorneys
Cheney & Kelley, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-07051 & 83-08243
August 30, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review, and Industrial Indemnity Company cross-requests review, of Referee Braverman's order which set aside Industrial Indemnity's denial and upheld the SAIF Corporation's denial of claimant's current low back condition, based upon his conclusion that claimant is presently suffering

from the residuals of her 1975 industrial injury, for which Industrial Indemnity is responsible, as opposed to a condition resulting from a new industrial injury, for which SAIF would be responsible.

Claimant's aggravation rights have expired in connection with the 1975 Industrial Indemnity claim. Claimant does not take issue with any portion of the Referee's order but has requested review as a protective measure in the event that the Board decides not to grant own motion relief pursuant to ORS 656.278. Thus Industrial Indemnity is the real party appellant.

Claimant had requested that the Board exercise its own motion authority and reopen her claim for a worsened condition allegedly related to her 1975 industrial injury. Because claimant's hearing requests were pending in this proceeding, in which there is an issue concerning employer/insurer responsibility, the Board deemed it appropriate to refer claimant's request for own motion relief to the Referee for consolidation with claimant's hearing requests. The Board entered an order accordingly on December 19, 1983 in Own Motion No. 83-0352M. The Referee conducted a consolidated hearing and, in addition to entering his order pursuant to ORS 656.289, addressing those issues properly before him in connection with claimant's 1975 claim and claimant's 1983 putative new injury claim, the Referee made a recommendation concerning claimant's request for own motion relief. That request for own motion relief is the subject of a separate order entered this day in Own Motion No. 83-0352M.

The only issue before the Board on de novo review of the Referee's order is the question of employer/insurer responsibility for claimant's worsened low back condition. We find little or no persuasive evidence of a new injury in 1983 and, therefore, affirm the Referee's order assigning responsibility to Industrial Indemnity in connection with claimant's 1975 injury. Claimant is not entitled to an attorney fee for services on Board review. See Robert Heilman, 34 Van Natta 1487 (1982).

ORDER

The Referee's order dated February 22, 1984 is affirmed.

CHARLES RIDDLE, Claimant
John J. Jacobson, Claimant's Attorney

Own Motion 84-0330M
August 30, 1984
Interim Own Motion Determination

On July 31, 1984 the Board issued an Own Motion Determination whereby claimant's claim was closed with time loss compensation terminated as of April 29, 1984. Claimant, by and through his attorney, has now advised the Board that there is a potential issue concerning the proper means of effecting claim closure, i.e., pursuant to ORS 656.268 versus 656.278. There is litigation pending in the Hearings Division (WCB No. 83-07951) and it appears that is the proper forum for resolving any such issue in the first instance.

The Board finds it appropriate, however, to relieve the insurer of any possible obligation to pay further time loss pending resolution of the claim closure issue. Accordingly, the insurer is authorized to terminate time loss payments as of April

29, 1984, as stated in our July 31, 1984 order. In all other respects, our July 31, 1984 order is rescinded.

This is an interim order and neither party has the right to appeal therefrom. Upon resolution of the litigation presently pending in WCB No. 83-07951, the parties shall advise how they wish to proceed in this own motion matter, whereupon a final order will be entered.

WAYNE L. VANCE, Claimant
Evohl Malagon, Claimant's Attorney
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-00281 & 83-00282
August 30, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Foster's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) affirmed Western Employer's denial of claimant's new injury claim; (3) assessed SAIF a 25% penalty on all compensation due from the date of disability "November 2, 1983," until their denial of April 27, 1983; and (4) awarded claimant $2,500 in attorney's fees. SAIF has also requested review of the Referee's refusal to reconsider his order and admit new evidence, and asks for remand for the consideration of such proffered evidence.

We deny SAIF's request for remand. Our review of the record reveals that this case has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

The Board affirms that portion of the order concerning responsibility for claimant's condition.

We modify those portions of the Referee's order which assessed SAIF a penalty for failing to pay interim compensation and which awarded claimant an attorney's fee.

A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation. ORS 656.273(3). Concerning aggravation claims, the first installment of interim compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition. ORS 656.273(6). Interim compensation is due only from the date of effective notice of a possibly compensable claim to the date of denial. Sally K. Cutts, 36 Van Natta 641, 642 (1984); Stone v. SAIF, 57 Or App 808 (1982); Donald Wischnofske, 34 Van Natta 664 (1982).

Claimant sustained a compensable low back injury while working for SAIF's insured in 1976. On November 2, 1982, while working for Western Employers' insured, claimant experienced what we have determined to be an aggravation. Claimant filed a new injury claim which was denied by Western Employers on December 30, 1982.

By letter dated January 10, 1983 claimant's counsel requested that the Compliance Division designate a paying agent pursuant to ORS 656.307. Claimant's counsel directed a copy of this letter to

SAIF. This appears to be SAIF's first notice of this matter. By letter dated January 18, 1983 the Compliance Division requested that SAIF provide written clarification of its position. On February 7, 1983, in response to a SAIF letter of January 26, 1983, claimant's counsel asked Western Employers to provide both the claimant and SAIF with all medical reports in its possession. SAIF received the medical reports on March 25, 1983 and issued its denial on April 27, 1983. The medical reports verified claimant's inability to work as a result of his worsened condition. SAIF did not pay interim compensation.

The Referee found that interim compensation should have commenced as of November 2, 1982, the date of disability. Additionally, he assessed a 25% penalty and an associated attorney's fee on all compensation due from the date of disability until SAIF's denial.

We find that interim compensation should have commenced March 25, 1983, the date SAIF received medical verification of his inability to work resulting from claimant's worsened condition, and continue until April 27, 1983, the date of its denial letter. SAIF was only obligated to pay from the date of notice of the claim, not the date of claimant's disability. Of course, since SAIF is the responsible party it must pay the same amount of compensation commencing from the date of disability. However, as we discussed in Sally K. Cutts, supra, this compensation takes the form of time loss rather than interim compensation.

Additionally, the Referee's order contains an apparent clerical error. The order states that SAIF shall pay claimant a 25% penalty on all compensation due claimant from November 2, 1983 until its denial of April 27, 1983. The Referee apparently meant November 2, 1982. We find that temporary total disability compensation should commence on November 2, 1982. However, we assess the penalty based only on the interim compensation due between the date SAIF received notice of a possible aggravation claim, March 25, 1983, and the date of its denial, April 27, 1983.

Finally, the Referee awarded claimant's counsel $2,500 for reversing SAIF's denial and for SAIF's failure to properly pay interim compensation. SAIF contends such an award is excessive. We agree and reduce the attorney's fee to award $1,500 for overturning the denial and $300 for prevailing on the interim compensation issue.

ORDER

The Referee's order dated September 29, 1983 is affirmed in part and modified in part. That portion of the order which ordered the SAIF Corporation to pay claimant a penalty for failing to pay interim compensation is modified. The SAIF Corporation shall pay to claimant a penalty of 25% of the interim compensation due from March 25, 1983 until its denial of April 27, 1983. Temporary total disability shall commence November 2, 1982. No penalty shall be applied to this amount of compensation. The Referee's award of $2,500 in attorney fees shall be modified as follows: Claimant's attorney is awarded $1,500 for reversing SAIF's denial of April 27, 1983 and $300 for prevailing on the interim compensation issue. Claimant's attorney shall receive $300 for services on Board review to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

GILBERT K. BROWN, Claimant
Owens & Hattenhauer, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-01119
August 31, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Leahy's orders which upheld the insurer's denial of medical services. We reverse.

Claimant suffered a compensable injury in the left shoulder blade area in April 1977 when he fell against a piece of angle iron. He saw several doctors in 1977 and 1978 complaining of left shoulder blade pain which sometimes extended into his neck and chest. The doctors reported that claimant had swelling around the left shoulder blade area; also a lump was found in that area which was thought to be a lipoma or cyst. In December 1978 Dr. Noall noted crepitation in the left shoulder, which other doctors had noted, and reported that claimant probably had scar tissue at the tip of the scapula which was related to the injury and which was causing symptoms in this area. Dr. Noall did not see a clear relationship between claimant's neck complaints and the industrial injury.

Claimant testified that from 1979 through 1981 he saw doctors at approximate six month intervals for continuing left shoulder blade symptoms. Some Kaiser medical records, most of which are hard to decipher and appear to be undated, offer limited corroboration for this testimony, i.e., one Kaiser record of shoulder blade area treatment is dated August 1981.

In November 1982 claimant was seen by Dr. Motz presenting the same complaints, who reported that claimant's condition and need for treatment were related to his 1977 injury. Dr. Motz's treatment and report to that effect prompted the insurer's partial denial of further medical services here in issue.

The Referee concluded that claimant had not sustained his burden of proof because: (1) Dr. Noall could not find a clear relationship between claimant's symptoms and his industrial injury; and (2) there were no medical reports supporting claimant's testimony that he sought medical attention for his left shoulder blade injury between 1979 and 1981.

We disagree. The Referee did not question claimant's credibility and we have no reason to question it. We thus accept claimant's testimony that he sought medical attention for his shoulder blade condition over the years in question. We are not aware of any doctrine that makes corroboration of such testimony essential but, if there were such a doctrine, we would find limited corroboration in the Kaiser records noted above. Moreover, we note that claimant's history and symptoms have been consistent in all medical reports, that no doctor has stated that claimant's shoulder blade area symptoms are unrelated to his industrial injury and that all doctors who have given an opinion have related claimant's shoulder blade problems to the 1977 injury. For all of these reasons, we conclude that claimant continues to be entitled to medical services under ORS 656.245 for conditions related to his left shoulder blade injury, and that the insurer's partial denial to the contrary must be set aside.

Claimant's motion for remand to supplement the record is denied.

ORDER

The Referee's orders dated November 18, 1983 and January 4, 1984 are reversed. The insurer's partial denial dated January 26, 1982 is set aside and this claim is remanded to the insurer for continued payment of medical services under ORS 656.245. Claimant's attorney is awarded $700 for services at hearing and $400 for services on Board review, to be paid by the insurer.

JOHN W. O'DELL, Claimant
Rolf Olson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-02427
August 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Brown's order which: (1) awarded claimant 160° for 50% unscheduled permanent disability, whereas the Determination Order awarded 112° for 35% unscheduled disability; (2) awarded claimant's attorney a fee of $300 for services regarding setting aside the SAIF Corporation's partial denial of claimant's psychological condition. Claimant contends that he is permanently and totally disabled and that he is entitled to a greater attorney fee. SAIF requests that claimant's permanent disability be reduced to 35%.

The Board affirms the Referee's permanent disability award. Regarding the attorney fee issue, the Board agrees that claimant's attorney is entitled to a greater attorney fee in connection with the partial denial and awards an additional fee of $200.

ORDER

The Referee's order dated January 13, 1984 is affirmed in part and modified in part. Claimant's attorney is awarded an attorney fee of $200 in addition to the $300 fee awarded by the Referee for services performed in connection with the partial denial, to be paid by the SAIF Corporation.

KEVIN E. OFZARZAK, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05913
August 31, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of that portion of Referee Galton's order which awarded claimant's attorney a $400 insurer-paid fee based on what the Referee termed SAIF's "unreasonable refusal and delay in acceptance or denial of the aggravation claim." There is no "refusal" or "denial" involved in this case; the question is whether there was any unreasonably delayed acceptance. It is clear to us that SAIF accepted claimant's aggravation claim within the 60 days permitted by statute; there is thus no basis for ordering an attorney fee.

Claimant sustained a compensable wrist injury in September

1978. His claim was previously closed. On July 7, 1982 SAIF received a request from claimant's physician for authorization to perform wrist surgery. The parties now agree that this request constituted an aggravation claim, and seem to agree that it did not create an obligation to pay interim compensation because it did not include verification of inability to work.

On August 26, 1982, well within 60 days of receiving this aggravation claim, SAIF sent a letter to claimant's physician and to claimant's attorney stating that the surgery was authorized, i.e., accepting the claim. Claimant was hospitalized for the surgery on October 12, 1982. SAIF timely paid temporary disability benefits after claimant was hospitalized and thus was unable to work.

The Referee apparently thought that SAIF's August 26 letter authorizing surgery was for some reason not sufficient to constitute an acceptance of the aggravation claim. We are at a total loss to comprehend how that letter could possibly have been interpreted by anybody involved as anything other than a complete acceptance of all that was then being claimed -- advance authorization for surgery. Admittedly, SAIF's notice of acceptance went to claimant's doctor and lawyer, and not directly to claimant. However, notice to an agent is generally notice to a principal; and, in any event, there is no suggestion that claimant did not personally learn of SAIF's position from his doctor or lawyer. Only form, and certainly not substance, suggests that anything different or additional should have been done under these circumstances.

Later, when the surgery took place, there was an additional "claim" for time loss which SAIF "accepted" by beginning to pay time loss within 14 days of claimant's hospitalization. Only form, and certainly not substance, suggests that anything different or additional should have been done by way of response to this additional claim.

ORDER

The Referee's orders dated January 20, 1984 and February 3, 1984 are affirmed in part and reversed in part. That portion of the Referee's orders which awarded claimant's attorney an insurer-paid fee of $400 is reversed. The balance of the Referee's orders is affirmed.

GERALD M. SAXE, Claimant
Huffman, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-01233
August 31, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of those portions of Referee Pferdner's order which awarded claimant a total of 208° for 65% unscheduled low back disability and 60° for 40% loss of the right leg, on review of a Determination Order which awarded 40% (128°) unscheduled and 15% (22.5°) scheduled permanent partial disability. The insurer contends that the Referee's increased permanent disability awards are excessive.

The Referee also concluded that claimant had not established good cause for failing to request a hearing within 60 days of the insurer's partial denial of a gastrointestinal disorder. In addition to filing his respondent's brief addressing the extent of disability issues raised by the insurer/appellant, claimant submitted a "motion" requesting that the Board "reconsider and . . . award on its own motion the claimant's request for payment in regard to the gastroenterology work which was performed . . . during and after his hospitalization for lumbar surgery in August 1982." In support of this "motion," claimant has submitted various portions of the record that are otherwise before us for de novo review pursuant to ORS 656.295.

We will consider the substance of claimant's "motion," but not in the exercise of our discretionary own motion authority, ORS 656.278; rather, although not the ideal way to do things, we think that claimant's "motion" sufficiently raises the good cause issue for review. See Jimmie Parkerson, 35 Van Natta 1247 (1983).

On the merits of the good cause issue, we affirm and adopt the relevant portions of the Referee's order.

On the extent of disability issues, we find that the Referee's award of 65% unscheduled disability appropriately compensates claimant for the loss of earning capacity attributable to this industrial injury. However, we conclude that the additional award of scheduled disability is excessive, and that the Determination Order adequately compensated claimant for the loss of use of his right leg.

Claimant has undergone two low back surgeries as a result of this 1979 industrial injury. Shortly after the injury, claimant submitted to a lumbar laminectomy for removal of a ruptured L5-S1 disc. More recently, in August 1982, claimant submitted to a second surgical procedure for exploration of the L5-S1 nerve roots bilaterally and for removal of a ruptured disc at the L4-5 level on the left.

Post-surgically claimant continues to experience low back and right leg pain. He has difficulty standing or sitting in one position for any length of time. There is no separate leg impairment; claimant's loss of use of his right leg is a direct result of his low back injury and surgery. Claimant's right leg pain is in the nature of radiating pain frequently encountered in significant low back injuries with nerve root involvement.

Dr. Nash's March 3, 1983 report noted decreased strength in claimant's right lower leg, a loss of three centimeters in the circumference of claimant's right calf in comparison with his left, and minor weakness of the toe flexors and the peroneal muscle group on the right as compared to the left. The relevant work restrictions noted at this time were no repetitive bending, no lifting from the floor, no climbing or crawling, and the availability of an opportunity to change positions frequently from sitting to standing to walking. As did the Referee, we find claimant's hearing testimony about his leg problems to be consistent with the limitations reported by Dr. Nash.

We cannot and do not, however, agree that these findings

either as reported by Dr. Nash or as reported in somewhat more detail in claimant's testimony can possibly support such a large award of scheduled leg disability for what started as an unscheduled back injury -- at least, not without a significant reduction in claimant's unscheduled award. We conclude from the record that claimant suffers from mild right leg impairment due to pain and weakness. We further conclude that the Determination Order, which awarded claimant 22.5° for 15% scheduled disability, adequately compensates claimant for this mild leg impairment, at least when viewed as secondary to claimant's more serious back disability for which he has been separately compensated.

ORDER

The Referee's orders dated August 19, 1983 and August 24, 1983 are affirmed in part and reversed in part. The portion of the Referee's orders which awarded 60° (40%) for right leg disability is reversed; and, in lieu thereof, the Determination Order's award of 22.5° for 15% loss of use of claimant's right leg is reinstated and affirmed. The remaining portions of the Referee's orders are affirmed.

JOHN P. KLEGER, Claimant
Allen & Vick, Claimant's Attorneys
Richard Pearce, Defense Attorney

WCB 83-10245
September 6, 1984
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

The employer has requested review of Referee Mulder's order which "modified" the employer's denials and ordered the employer to provide claimant with "recommended surgery and other benefits relating to C6-7." Claimant has now moved for remand for the Referee to clarify the order. Claimant argues that it was his understanding that interim compensation was due under the Referee's order but that interim compensation has not commenced to date. The employer has not responded to claimant's motion. Claimant also informs the Board that he has filed a request for hearing on the issue of nonpayment of the interim compensation allegedly due under Referee Mulder's order. The hearing is set before Referee Pferdner on September 10, 1984.

We find that the record has been improperly, incompletely or otherwise insufficiently developed. The case is remanded to the Referee for clarification of his order. The hearing currently scheduled before Referee Pferdner on September 10, 1984 should be heard in tandem with this case on remand.

ORDER

This case is remanded to the Referee for proceedings consistent with this order.

GERALDINE P. BROWN, Claimant
Welch, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 82-09846
September 13, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Shebley's order which set aside the Determination Order dated October 20, 1982, finding that the claim was prematurely closed as of September 22, 1982.

Claimant suffered a compensable low back strain on October 31, 1981 while straightening up after bending over to get a chart out of a file cabinet. At the time of her 1981 injury claimant had preexisting degenerative arthritis in her low back. Claimant also had sustained two prior injuries to her low back while employed with this same employer; however, she received no permanent disability awards for those injuries.

Claimant was treated by Dr. Martin, chiropractor, and then, in December 1981, she was seen by Dr. Post, orthopedic surgeon, who became her treating orthopedist. Since claimant continued to have complaints of pain, Dr. Post referred her to Dr. Rosenbaum, neurosurgeon, who reported on August 3, 1982 that he could find no evidence of significant radiculopathy and he did not recommend performing myelography or CT scans based on his findings.

Finally, on September 22, 1982, Dr. Post recommended that claim closure be appropriate. He found that claimant had continuing problems but that she was medically stationary with some permanent impairment. Thereupon the Determination Order was issued on October 20, 1982 which awarded time loss benefits from October 31, 1981 through September 22, 1982 and 10% unscheduled permanent disability benefits for claimant's low back injury. Also on October 20, 1982, Dr. Post modified his release somewhat by stating claimant should return only to part-time work. Then, on November 2, 1982, Dr. Post released claimant to return to her former job with no restrictions.

Claimant finally returned to regular work on November 9, 1982 but left after about two days because of low back pain complaints. At that time Dr. Post wrote claimant a note requesting that she be off work for about one week. He testified that he did this more as an accomodation to claimant, although he still had the opinion that her condition was medically stationary. As of November 15, 1982 Dr. Post did not believe that claimant's condition had worsened. Claimant stopped seeing Dr. Post after he informed her that he had no basis for thinking her unable to carry out her present occupation and that he would not authorize time loss beyond the week of November 15 through 19. He testified that he felt claimant could work during that time but again he authorized time loss as an accomodation to her. He indicated in his report of November 23, 1982 that claimant said she might start seeing a chiropractor instead of him and on November 19, 1982 she, in fact, began treating with Dr. Holman, chiropractor. Dr. Holman has never found claimant medically stationary.

Claimant was also seen on a one-time basis by four other

doctors: Dr. Pasquesi, Dr. Kappes, Dr. Schuler and Dr. Puziss, some of whom gave opinions on whether claimant's condition was medically stationary but none of whose opinions are particularly persuasive as they had no basis of comparison as did Dr. Post or Dr. Holman. As between those two doctors, we find Dr. Post's opinion the more persuasive.

Claimant was examined by Dr. Post on October 12, 1983, which took place approximately one year after her last visit with him. At that time Dr. Post found no material or significant differences in claimant's condition and he felt that, if anything, claimant's condition had improved during the intervening year. The record shows that in the intervening year Dr. Holman did not treat claimant between February and July 1983. When she finally did return to Dr. Holman for treatment in July 1983, it was for an unrelated condition.

While it appears from claimant's testimony that she did have some improvement in the time after September 22, 1982, it does not also appear that Dr. Holman's treatment was entirely curative as claimant continued to have fluctuations in her back pain complaints. No treatment other than conservative treatment has ever been recommended for claimant. Considering the gap in treatment with Dr. Holman and the fact that his treatment remained conservative throughout the intervening period of time, we find his opinion that claimant was not stationary less persuasive than the opinion of Dr. Post, who regularly treated claimant in the year following her injury up until the time he found her medically stationary. Dr. Post was also in a position to examine her one year later and continued to conclude that her condition was medically stationary. Therefore, we reverse the Referee's order and affirm the Determination Order insofar as it awarded claimant temporary disability benefits only through September 22, 1982.

We have taken official notice that claimant has another claim now pending, which is an appeal of a second Determination Order which resulted from the closing of her claim subsequent to Referee Shebley's order in this case. Since the extent of her permanent disability will be determined in that proceeding, we are remanding this claim to the Hearings Division for consolidation to determine the extent of claimant's permanent disability due to her October 1981 injury.

Finally, we do not find adequate evidence that claimant's condition worsened in December 1982 and, therefore, approve the insurer's denial of that aggravation claim.

ORDER

The Referee's order dated November 7, 1983 is reversed and this case is remanded to the Hearings Division for consolidation with claimant's pending hearing with regard to the extent of her permanent disability due to her October 31, 1981 low back strain.

JIMMIE PARKERSON, Claimant
Gatti & Gatti, Claimant's Attorneys
Donald Howe, Ass't. Attorney General
Lindsay, et al., Defense Attorneys

WCB 82-07754, 82-07755, 82-07756 & 82-11210
September 13, 1984
Order on Reconsideration

We entered our Order on Review herein on August 29, 1984. 36 Van Natta 1240 (1984). Claimant thereafter requested reconsideration of those portions of our order which vacated the Referee's award of unscheduled permanent partial disability and reversed the Referee's imposition of a penalty and associated attorney's fee.

With regard to the penalty/attorney fee issue, claimant presents no argument which persuades us that our conclusion is in error. Therefore, we adhere to that portion of our order.

With regard to the issue concerning the Referee's award of permanent partial disability, we likewise decline to modify our prior order. The Referee found that claimant sustained a new injury, responsibility for which rested with EBI Companies as the insurer for claimant's more recent employer. We concluded that claimant had sustained an aggravation of a prior injury sustained while he was an inmate in the Oregon State Penitentiary. It was in connection with this same injury that the Referee awarded claimant 10% unscheduled disability. Claimant makes no contention that he was medically stationary at the time of hearing. Indeed, in his request for reconsideration, claimant states that he is not now medically stationary. We found it unnecessary to address the issues concerning permanent disability in this proceeding, based upon our conclusion that, "When claimant's condition is once again determined to be medically stationary, the Fund will be required to reclose [the] claim, at which time claimant will be entitled to a new determination concerning permanent disability, if any . . . . " Claimant's contention that he is entitled to the permanent disability award granted by the Referee and to a reevaluation upon reclosure is inconsistent with our decision in Gary A. Freier, 34 Van Natta 543 (1982), and, quite simply, wrong. Also see Kociemba v. SAIF, 63 Or App 557, 560 (1983). For this reason, we adhere to our prior decision.

ORDER

On reconsideration of our Order on Review dated August 29, 1984, we adhere to our prior order, which is hereby readopted and republished effective this date.

DONALD CASIDA, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-01539
September 14, 1984
Order on Review

Reviewed by the Board and en banc.

The SAIF Corporation requests review of Referee Podnar's order which set aside its denial of claimant's myocardial infarction claim. The only issue is compensability.

Some of the facts are generally undisputed:

(1) Claimant had preexisting, but not previously diagnosed,

arteriosclerotic cardiovascular disease that was a significant factor in causing the heart attack here in issue.

(2) Claimant was involved in a meeting at work that he perceived as emotionally stressful on Friday, November 13, 1981. He began to experience symptoms on that day that we now know, with the benefit of hindsight, were probably cardiac-related, although at the time claimant believed his symptoms to be gastric-related.

(3) Claimant's symptoms persisted at apparently fluctuating levels throughout the weekend of November 14-15, although, as discussed more fully below, the exact nature and intensity of those symptoms is not clear to us. It is agreed that claimant's symptoms became more acute when he carried some firewood into his house on Sunday, November 15.

(4) By Monday morning, November 16, claimant felt well enough to attempt to return to work, but shortly after his arrival at work his symptoms got to the point that he went to an emergency room and was admitted to the hospital with a diagnosis of myocardial infarction.

(5) Claimant's actual infarction was sometime over the weekend while he was at home, not involved in any work activities. Dr. Roberts, claimant's treating doctor, opines that claimant's infarction was on Saturday, November 14, but does not explain the basis of that opinion. Dr. Kloster interprets serum enzyme blood levels recorded at the time of claimant's hospital admission as indicating that his infarction was most likely within the prior 24 hours, i.e., on Sunday November 15. Dr. Griswold interprets the same data as indicating that claimant's infarction was most likely within the prior 24 to 36 hours, i.e., late Saturday or early Sunday. There are thus differences regarding whether the infarction was on Saturday or Sunday, but apparent agreement -- as best as such things can ever be known -- that it was during the weekend.

Against this background, the area of dispute is whether the at-work events of Friday, November 13 were a material cause of claimant's at-home infarction during the weekend. Drs. Griswold and Kloster, both of whom testified by deposition, present conflicting opinions on this ultimate question.

In summary, Dr. Kloster opined that claimant's Friday work activity did not materially contribute to claimant's subsequent heart attack; that the heart attack was due to the progression of claimant's atherosclerosis; and that the at-work events on Friday at most produced temporary angina symptoms, but that at that time "there was no damage done as far as the heart muscle is concerned, and no progression as far as narrowing of the arteries." Dr. Kloster concluded: "My interpretation would be that the preexisting and underlying coronary atherosclerosis [had] progressed to the point where [claimant] was having symptoms which were related to the job activities, but that an infarction was imminent and impending and perhaps unavoidable, and would have occurred regardless of the emotional stress of that meeting [on Friday at work]."

In summary, Dr. Griswold opined that claimant's Friday work

activity did materially contribute to claimant's subsequent heart attack because "something happened" at that time "to change his coronary artery circulation"; and that this hypothesis was supported by the fact that claimant remained symptomatic over the weekend, whereas Dr. Griswold would have expected temporary angina chest pain to resolve within ten minutes at the most. Dr. Griswold concluded: "I can't deny the possibility that this is purely coincidence, [but claimant's] continuing symptoms [over the weekend] I feel probably . . . was [sic] a materially substantial contributing cause to his unstable picture, which led to his infarction."

Both Dr. Kloster and Dr. Griswold elaborated with additional and well-stated reasons for their respective positions.

One possible basis for finding one of these expert opinions more persuasive than the other would be clear and detailed evidence about the nature and intensity of claimant's symptoms on Saturday and Sunday. Dr. Kloster apparently understood that claimant had a lower level of symptoms during the weekend, which would be more consistent with the natural progression of claimant's cardiovascular disease. Dr. Griswold apparently understood that claimant had a higher level of symptoms during the weekend, which would be more consistent with his thesis that "something happened" to claimant's coronary artery circulation in connection with the Friday work events. We find that the balance of the record does not clearly support either position. Dr. Wasenmiller's one report, which we otherwise do not find helpful on the causation question, recites a history of: "The [chest] discomfort resolved and, Friday evening, [claimant] experienced arm discomfort only." Dr. Griswold obtained a history of general fatigue over the weekend. Claimant testified that he went to a dinner engagement after work on Friday, but left early because he felt like he was coming down with flu; that on Saturday his distress "seemed to ease"; that he had an incident of feeling "tightness in the chest" on Sunday afternoon; but that he "didn't feel too badly Monday morning" and decided to try to go to work. We are unable to tell from this evidence whether claimant's symptoms over the weekend are more consistent with Dr. Kloster's analysis or are more consistent with Dr. Griswold's analysis and, unfortunately, no doctor was asked that specific question.

In order for claimant to sustain his burden of proof in this case, we would have to be able to say that we find Dr. Griswold's opinion more persuasive than Dr. Kloster's opinion. We are unable to do so. Considering all of the detailed explanations that both experts offered for their respective positions, we find the evidence to be in equipoise.

ORDER

The Referee's order dated December 30, 1983 is reversed. The SAIF Corporation's denial dated January 8, 1982 is reinstated and affirmed.

Board Member Lewis Dissenting:

I agree with Referee Podnar that the preponderance of evidence is that claimant's heart attack was precipitated by a particularly stressful all day meeting at work and, therefore, that claimant's heart attack, as opposed to his underlying heart disease, is compensable.

Claimant, a then 56 year old assistant director of the Oregon School Nutrition Program, experienced chest and arm pain with nausea and light-headedness while on the job Friday afternoon, November 13, 1981. Claimant had never before experienced such symptoms. Claimant testified as to the continuing nature of his symptoms from Friday through Monday, both in his deposition taken by the SAIF Corporation's investigator, December 22, 1981, and at hearing.

On Friday, he was conducting an all day meeting with his staff during which there was considerable disagreement over certain policies and procedures that claimant had decided should be implemented. When the symptoms of chest and arm pain with nausea began that afternoon, claimant did not recognize them as connected to a problem with this heart but, rather, attributed them to indigestion or the flu. Friday night he had a dinner engagement which he attended, but he had to leave early due to his continuing symptoms. Claimant testified that Friday night his chest pain had eased somewhat, but that his continuing arm pain made him unable to sleep that night.

Saturday, claimant's pain eased but he continued to feel poorly and was unable to do anything but sit around the house. By early Saturday evening, claimant felt totally exhausted and went to bed early.

Sunday, claimant again felt exhausted in the same way he had on Friday. About noon, he carried an armload of firewood indoors and at that time he experienced the more intense pains he had felt on Friday afternoon.

Monday morning, claimant testified that his arm and chest did not ache quite as much and he decided to go to work. Shortly after claimant arrived, however, and while he was preparing for the morning staff meeting, his symptoms increased. He asked his coworker and friend, Ruby Cox, to take him to the hospital emergency room. He described his symptoms at that time as the same he had felt on Friday and Sunday. At the hospital, enzyme tests were performed which showed that claimant was experiencing a heart attack.

Claimant was evaluated by Dr. Wasenmiller, cardiologist, on December 22, 1981 at SAIF's request. A fair reading of Dr. Wasenmiller's opinion is that, while work activities did not cause the underlying heart disease, the emotionally stressful staff meeting on Friday, as well as the physical activity of carrying an armload of wood on Sunday precipitated claimant's angina and heart attack.

Claimant was later examined by Dr. Griswold, cardiologist, on February 15, 1983. Dr. Griswold also examined claimant's medical records. Dr. Kloster, also an experienced cardiologist, examined the medical records only sometime before his deposition in October 1983. These two medical experts agree that the stress claimant experienced at work on that Friday afternoon precipitated symptoms of angina that would have required medical treatment had claimant recognized what they were. The doctors also agree that it is not possible to definitely determine from the enzyme tests taken on Monday when the actual heart attack began. In deposition, Dr.

Kloster first stated that the heart attack could possibly have started as early as Friday. However, when later pressed for a more definite answer, he finally stated that the heart attack more probably began on Sunday, given the level of enzymes found on Monday. Dr. Griswold was also deposed in October 1983. He thought that the enzyme study indicated that the heart attack probably began Saturday night or Sunday, but he did not exclude the possibility that a heart attack could have also occurred Friday. He realized, however, there was no way to prove or disprove that theory since the appropriate tests had not been administered on Friday or Saturday.

The area where the doctors disagree is the relatedness of the Friday episode to the known heart attack that occurred, most likely, on Saturday or Sunday. Dr. Kloster is of the opinion that the Friday incident was a temporary and separate episode of angina that was unrelated to the heart attack which was discovered in the Monday morning tests. He notes that claimant had preexisting atherosclerosis and it was his opinion that the heart attack was only evidence of the natural progression of that disease. In other words, it was Dr. Kloster's opinion that the timing of the heart attack was a random event, unrelated to the Friday onset of symptoms. On the other hand, Dr. Griswold was of the opinion that the Friday angina and eventual heart attack should be viewed as one related sequence in that the Friday angina marked the beginning of the pre-infarction syndrome which led directly to the Saturday or Sunday heart attack, which was finally diagnosed by tests on Monday morning.

Dr. Griswold's theory that there was one related sequence of causation, rather than two distinct events, is supported by the testimony of claimant and his witnesses. Both claimant and his witnesses, Mr. Larson, former employe, and Ms. Cox, friend and former employe, testified that the Friday all day staff meeting was indeed a tense and stressful one. Claimant testified both in his deposition in December 1981, and at hearing that his symptoms which began on Friday never returned to normal after the onset, although they did ease at times with rest, as well as increase at times. Ms. Cox accompanied claimant the entire weekend. She corroborated his testimony by stating that claimant felt poorly Friday and throughout the weekend, although he felt somewhat better on Saturday. There is nothing in the record which shows this testimony to be unreliable and this testimony directly supports Dr. Griswold's theory of a single related sequence as opposed to Dr. Kloster's theory of separate events.

In a case of this type, where it is proposed that work related emotional stress led to a myocardial infarction, it is necessary to view the facts on a case by case basis to determine whether compensability has been proved. Bales v. SAIF, 294 Or 224 (1982). Both Dr. Griswold and Dr. Kloster possess excellent credentials as qualified cardiologists, but when examining each doctor's theory in light of the credible testimony in this case, Dr. Griswold's theory is the more probable and persuasive.

Given the evidence of work events preceding claimant's attack, the credible testimony of the lay witnesses and the opinion of Dr. Griswold and Dr. Wassenmiller, I find it improbable that the heart attack was a random occurrence. The stress of claimant's job was a material contributing cause of the heart attack. Therefore, I respectfully dissent from the majority's opinion and would affirm the Referee's order finding this claim compensable.

RONALD ISOM, Claimant
Steven Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-07005
September 14, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Seymour's order which set aside its denial of claimant's industrial injury claim for a herniated disc at L4-5 of the low back.

Claimant has suffered both on the job and off the job low back injuries since 1978. The most recent off the job incident occurred on May 5, 1983 when claimant strained his back lifting a television set. At the time he felt a pop in his back, was taken to the hospital emergency room, x-rayed, given pain medication and released.

Claimant became employed by this employer on May 30, 1983 as a shoe repairman. This job was sedentary and did not require heavy lifting. Claimant had good attendance and it does not appear that he lost any time from work because of back problems.

At 3 p.m. on July 7, 1983 claimant was working alone in the shop except for a high school boy named Charlie who claimant paid $10 a week to do various chores about the shop, such as sweeping, washing windows and dumping trash. At that time, claimant made a telephone call to his employer to ask about his job status since claimant had heard a rumor that he was to be terminated. The owner informed claimant that he would be terminated the next day due to poor workmanship. Claimant continued working and sometime prior to 4:30 told Charlie that he was going outside to dump the trash, rather than Charlie. Claimant had never dumped the trash before. Charlie did not see what claimant did when claimant left the shop to dump the trash. However, claimant testified he took the garbage can, tipped it on its side and rolled it to the dumpster and that he then lifted the can up to dump the trash into the dumpster when he injured his back. Claimant came back into the shop and asked Charlie to dump the trash because his back hurt. Claimant apparently then called for an ambulance and was taken to the hospital emergency room where he was advised by Dr. Buck to have a week of bed rest. Claimant did return home to bed rest, but by July 13, 1983 claimant's condition became so acute that an ambulance was again called and he was taken to the hospital and seen by Dr. Golden. A herniated disc at L4-5 was eventually diagnosed and claimant underwent a laminectomy and discectomy at that level on August 19, 1983 by Dr. Golden.

The Referee found that claimant was not a credible witness and that, when claimant went out to dump the trash at 4:30 on July 7, 1983, he intended to falsely report to Charlie and others that he had injured his back while dumping the garbage so that he would be able to get workers' compensation benefits after he was terminated. The Referee further found that claimant actually injured himself while lifting the garbage can, that he had not intentionally injured himself, and that it was Dr. Golden's opinion that the lifting incident as described by claimant was the cause of the necessity for surgery at L4-5. Thereupon he found the claim to be compensable. We reverse.

ORS 656.156 prohibits a worker from receiving benefits if the

injury results from the deliberate intention of the worker to produce such an injury. Given claimant's lack of credibility it is not unlikely, from the facts before us, that he did intend to cause some type of minor back strain upon which he could claim workers' compensation benefits. The fact that he "got more than he bargained for" and actually sustained a herniated disc does not mean that he did not intend to injure himself, at least in a minor way.

Further, even if claimant did not intentionally injure himself, given his lack of credibility, there is no way of knowing whether he actually injured himself at the time he lifted the garbage can. The lifting incident was unwitnessed and it is possible that claimant did not injure himself at all at that time. The findings in the emergency room on July 7, 1983 were of tenderness to pressure over the low back area with some limitation of motion and some pain upon left leg straight leg raising at 40 degrees. There was no sensory loss, no apparent muscular weakness and deep tendon reflexes were equal and normal bilaterally at the knees and ankles. X-rays of the spine were normal. These are symptoms that are not inconsistent with his prior back injuries. It was not until a week after the alleged lifting incident that medical evidence was obtained finding that claimant had a herniated disc. Dr. Golden's opinion that the lifting incident occurred and that the herniation must have occurred at that time was entirely based on the history that claimant related.

Although it is possible that a herniation did occur at the time of the alleged unwitnessed lifting incident, we are unable to reach such a conclusion given claimant's lack of credibility, with no corroborating evidence. Therefore, while it is true that claimant did suffer a herniated disc which required surgery, we find claimant has failed to prove by a preponderance of the evidence that the herniation actually was caused by his lifting of the garbage can at work.

ORDER

The Referee's order dated February 3, 1984 is reversed in part. The SAIF Corporation's denial dated July 21, 1983 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

ALBIN JOHNSON, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-06056
September 14, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee Podnar's order which set aside its denial of further medical benefits for claimant's cervical and thoracic condition and his osteoarthritis condition pursuant to ORS 656.245.

On November 13, 1979 claimant strained his low back lifting some lawn mowers out of a pickup truck while working for the employer. Dr. Chitty, the treating physician at the time, released claimant to modified work after one week.

In May 1980 claimant began seeing Dr. Hazel, an orthopedic surgeon. At the time of the initial visit, Dr. Hazel opined that

claimant had a strain injury which had largely subsided, but suffered from obvious hypertrophic osteoarthritis of the back.

In July 1980, Dr. Boyden performed an independent medical examination at the employer's request. He opined that claimant had a chronic lumbosacral strain. He stated that claimant was then medically stationary. A Determination Order issued on July 18, 1980 with no award for permanent disability.

Dr. Hazel has continued to treat claimant's back problems throughout the history of this claim. The general tenor of his reports is that he is providing palliative treatment to claimant's osteoarthritis. As the claim history has progressed, Dr. Hazel's reports have gradually begun to mention pains in the upper and mid back areas as well as the lumbar pains. The parties agree, however, that the first claim for cervical and mid-back problems was in May 1983. On June 6, 1983 the employer denied the cervical and mid-back problems as well as claimant's osteoarthritis. On November 21, 1983 Dr. Hazel reported:

> "It is my opinion at this time that that strain injury has long since resolved itself, although I cannot tell the exact time but it certainly is resolved by this time and it is my medical opinion that he no longer manifests the symptoms of the strain that he sustained in November, 1979.
>
> "His current treatment being provided by me is for generalized axial, hypertrophic osteoarthritis involving the low back, upper back and neck. It is my opinion that this osteoarthritis antedated his injury that the cause of it is unknown, suspected genetic, certainly not related to the injury that he sustained, and in my opinion, was not accelerated by that injury."

At hearing, the Referee held that under Bauman v. SAIF, 295 Or 788 (1983), the employer is now estopped to deny either the upper and mid back conditions or the osteoarthritis. We disagree. As soon as a claim was made for the upper and mid back conditions, the employer denied. Certainly, it cannot be said to be estopped from denying those conditions. So far as the osteoarthritis condition is concerned, Bauman does not preclude partial denials of compensation for conditions which the insurer has reason to believe are not causally related to the accepted claim. Clyde C. Wyant, 36 Van Natta 1067 (1984). Accordingly, the employer is not estopped from denying the osteoarthritis condition.

On the merits, we are persuaded by Dr. Hazel's reports that claimant's osteoarthritis, including the upper and mid back problems are not related to claimant's accepted injury of November 1979.

ORDER

The Referee's order dated December 30, 1983 is reversed. The employer's denial of June 6, 1983 is reinstated.

RAYNELL A. LOBATO, Claimant
Ormsbee & Corrigall, Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 83-04932
September 14, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Seymour's order which set aside its denial of claimant's aggravation claim.

On August 16, 1977 claimant strained his low back when he reached over to pick up some roofing while at work. The claim was closed by Determination Order dated June 5, 1978 which granted no award for permanent disability. Claimant received an award for 15% unscheduled disability by a stipulated order in November 1978. Claimant sought no treatment for his back from June 1978 until March 1983.

In March 1983 claimant reported to Dr. Whitney that his back pain had become increasingly more severe. Dr. Whitney stated: "He has a chronic back strain with obesity." The doctor noted that claimant had gained 30 to 40 pounds since he had last visited a doctor. He opined that claimant's condition had worsened.

In April 1983 Dr. Whitney opined:

> "The treatment that I am offering [claimant] is due to the aggravation of his activity and his weight change and hopefully, we will get him to improve to the point that he can return to his level, at which he participated, when last declared medically stationary. But, a lot of this will depend on the weight loss."

In September 1983 Dr. Whitney stated:

> "[Claimant] definitely had a back injury in 1977. His obesity is not causing his back injury, however, it can cause exacerbations and lack of improvement due to the extra weight. [Claimant] himself, has noted that when he gains weight the pain increases in his back and his ability to function decreases. The basic cause of his pain is the previous injury."

In January 1984 Dr. Serbu examined claimant and opined that "his problem is mainly related to his rather marked exogenous obesity, the patient having a mechanical type low back problem."

The Referee concluded that Nelson v. EBI, 296 Or 246 (1984), is inapplicable to this case because Nelson involved an extent of disability question whereas this case involves a denied aggravation claim. The Referee then applied Grable v. Weyerhaeuser, 291 Or 378 (1981), and found that claimant's compensable injury was a material contributing cause of claimant's worsened condition.

We disagree with the Referee's analysis. We have previously

concluded that the general principles articulated in Nelson also apply in the context of a denied aggravation claim. Dan Lingo, 35 Van Natta 1261 (1983). The Supreme Court's holding in Nelson is grounded in the proposition that "a claimant who has suffered personal injury has a duty to minimize his or her damages." 296 Or at 252. Likewise, a claimant who has suffered a compensable injury should not be entitled to additional compensation in the form of an aggravation claim because he or she has increased his or her physical impairment by gaining weight.

Claimant was informed in 1978 that he should lose weight. Despite that advice he gained weight. The expert medical evidence makes it clear that claimant's condition is now worse because he has gained significant amounts of weight. We do not believe this is sufficient to establish a compensable aggravation claim. Dan Lingo, supra.

ORDER

The Referee's order dated April 6, 1984 is reversed. The SAIF Corporation's denial dated May 12, 1983 is reinstated and affirmed.

JAY D. LOGGINS, Claimant
Kenneth Peterson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08796 & 82-06938
September 14, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of that portion of Referee Nichols' order which affirmed a January 3, 1983 Determination Order that awarded him no permanent partial disability for a neck injury.

In reaching our decision, we have considered not only the medical opinions pertaining to claimant's permanent impairment, but claimant's testimony concerning the effects of his disabling pain. See, Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

The Board affirms the order of the Referee.

ORDER

The Referee's orders dated December 27, 1983 and January 16, 1984 are affirmed.

WILLIAM H. O'BRYAN, Claimant
Emmons, et al., Claimant's Attorneys
Daryl Nelson, Defense Attorney
Cheney & Kelley, Defense Attorneys

WCB 83-08567, 83-01166 & 83-01188
September 14, 1984
Order on Reconsideration

The Board issued its Order on Review on August 24, 1984.

Claimant has requested reconsideration of the Board's Order contending he is entitled to a reasonable attorney fee for counsel's efforts on Board Review. Although responsibility was the sole issue raised on review, claimant contends the filing of a brief by his counsel was necessary to protect his interests.

The request is granted. We have adopted the standard of OAR 438-47-090, "active and meaningful participation," for determining

an entitlement to an attorney's fee on Board Review where the only issue on review is employer/insurer responsibility. Robert Heilman, 34 Van Natta 1487 (1982). Heilman interpreted "active and meaningful participation" to mean arguing a position that is adverse to one of the potentially responsible employers or insurers. 34 Van Natta at 1488. In the present case claimant submitted a brief thoroughly outlining the responsibility issue and discussing the current state of responsibility law. However, he took no position adverse to one of the potentially responsible parties. Instead he concluded the record supported either an aggravation or new injury theory. Accordingly, he is not entitled to an attorney's fee.

On reconsideration, the Board adheres to and republishes its former order.

IT IS SO ORDERED.

KEITH PHILLIPS, Claimant
Olson, et al., Claimant's Attorneys
Keith Skelton, Defense Attorney

WCB 80-06429
September 14, 1984
Order on Remand

This case is before the Board on Remand from the Court of Appeals with instructions to reinstate the Referee's order which upheld a Determination Order's award for permanent total disability. Phillips v. Liberty Mutual, 67 Or App 692 (1984).

The Referee's order dated June 11, 1982 is reinstated. Claimant is entitled to a carrier paid attorney's fee of $1,500 for services at hearing.

In addition, claimant's attorney is allowed an award of 25% of the increased compensation awarded under the Court of Appeals' order, not to exceed $1,870. ORS 656.388(4) and OAR 438-47-045. In setting this fee, the Board has considered the services of claimant's attorney at the Board level as well as before the Court of Appeals.

ORDER

The Referee's order dated June 11, 1982 is reinstated, including the attorney's fee awarded by that order. Claimant's attorney is allowed 25% of the increased compensation ordered by the Court of Appeals, not to exceed $1,870.

BILLY L. QUARING, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08613
September 14, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Mulder's order which held that claimant was eligible for vocational assistance and remanded the matter to the Field Services Division of the Workers' Compensation Department for appropriate processing. The issue is claimant's eligibility for vocational assistance.

(The Referee's order was issued on April 29, 1983. Effective July 1, 1984 the Field Services Division was abolished and

insurers and self-insured employers became directly responsible for providing vocational assistance subject to the regulatory authority of the Workers' Compensation Department. See ORS 656.340, 656.728; see also OAR 436-61-017, establishing the Rehabilitation Review Division within the Department.)

Claimant sustained a low back injury in December 1979 while he was working for Diamond Industries. The diagnosis was lumbosacral strain/sprain. He was released for and returned to regular work approximately four weeks post-injury. Claimant continued to work, although he continued to experience symptoms of back pain with some left-sided radiating pain. Claimant eventually terminated his employment with Diamond Industries and went to work with another employer performing a lighter job. The Diamond Industries claim was closed in October 1980 with an award of temporary total disability and 16° for 5% unscheduled low back disability. A March 1982 Referee's order increased claimant's permanent disability award to 144° for 45% unscheduled disability.

Claimant worked for only about four months for his new employer before he was laid off due to poor economic conditions. He then obtained employment with the Hillsboro School District as a janitor. Claimant worked for the school district from December 1980 until March 1982. On or about January 29, 1982 claimant sustained a nonindustrial finger injury, which prevented him from working.

After a period of recovering from the finger injury, claimant returned to work for the school district on April 18, 1982; he resigned from that position the next day. Claimant filed for and was found to be eligible to receive unemployment benefits. The school district requested a hearing to contest claimant's eligibility for unemployment benefits. In June 1982 an Employment Division hearing referee issued an order which upheld the prior decision that claimant was entitled to receive unemployment benefits. That referee's order states the following relevant findings of fact:

> "On or about January 29, 1982 the claimant injured his finger while off the job. After March 8, 1982, the claimant could not work because of his finger injury. On April 19, 1982, the claimant resigned in lieu of a discharge. The employer was going to discharge the claimant primarily due to his physical inability to perform and because it felt he had falsified his job application. The claimant does not read, and he answered 'yes' to the question on the job application that he could fulfill the requirements of the position."

The Employment Division referee concluded that claimant was not discharged for misconduct: "The claimant was discharged primarily because he was not physically able to perform his job. Such a reason does not warrant the imposition of a disqualification. The claimant had a finger injury." (Emphasis added.) With regard to the employer's allegation that claimant had falsified his job application, the referee stated: "It appears that the claimant answered the question truthfully,

especially in light of the fact that he worked for the employer for over two years."

On August 6, 1982 the Field Services Division notified claimant that he was not eligible for vocational assistance. The stated reason was that claimant had returned to work after his industrial back injury, and that his current unemployment was not a direct result of his industrial injury.

On January 10, 1983 claimant's physician reported that claimant experienced increased back and left leg pain with increased activity. He stated that "it would be nice" to enroll claimant in a vocational rehabilitation program in order to "get him retrained so he wouldn't have to do the janitorial work that would cause him symptoms."

Claimant requested that the Director of the Workers' Compensation Department review the decision that he was not eligible for vocational assistance. See former ORS 656.728(6); former OAR 436-61-998. The Director found former OAR 436-61-010(13) (effective January 1, 1982) and former OAR 436-61-100 (effective January 1, 1983) applicable and dispositive. These administrative rules provided:

> "Workers have no entitlement to services under these rules if . . . they have been reinstated or reemployed, but leave for reasons not directly caused by their compensable injury . . . "
>
> "All of the following conditions must be met for a worker to become eligible for vocational assistance . . . the worker has not, after the injury, obtained and then left suitable employment for a reason unrelated to the injury."

The Director concluded:

> "[Claimant] worked for over two years after the industrial injury. His last employment ended after he suffered an off-the-job injury. While it appears [claimant] is at a social disadvantage because of his illiteracy and the referenced intellectual deficit, I also note that he has worked steadily for many years in spite of these deficiencies. He may wish to apply for assistance at a social service agency, such as the Vocational Rehabilitation Division of the Department of Human Resources, to seek assistance in returning to suitable employment."

Claimant requested a hearing contesting the Director's decision. ORS 656.283. The Referee found a threshold issue to be whether the Director relied upon the appropriate administrative rule, in view of the fact that claimant was injured in December of 1979, at which time a different set of administrative rules governing vocational assistance were in effect. The rules that

were in effect on the date of claimant's injury provided in pertinent part:

> "(1) It is the policy of the Department to assist a vocationally handicapped worker in obtaining a job that is feasible, for which there are good prospects for continuing gainful employment, and which in other respects appears to be a reasonable solution to restoring the injured worker as soon as possible and as near as possible to a condition of self-support and maintenance.
>
> "(2) Vocational training will be provided only when the worker's inability to return to work is the result of a vocational handicap arising from his disabling occupational injury or disease. When possible, a vocationally handicapped worker should be trained in a job related to his former regular employment. Training in non-related work may be provided when there appears to be no other practical alternative." Former OAR 436-61-010.

Under these rules, a "vocationally handicapped worker" was defined as "a worker who is unable to return to his regular employment because of the permanent residuals of an occupational injury or disease, and who has no other skills, aptitudes or abilities which would enable him to return to gainful employment." Former OAR 436-61-005(4).

In this proceeding, the Referee found the more recent rules, i.e. those relied upon by the Director, applicable. He concluded that claimant left his job with the school district "for reasons directly connected to his industrial injury, that is, because of his back injury residuals which rendered him incapable of doing janitorial work."

We disagree. We conclude that, under either set of rules, claimant is not entitled to the vocational rehabilitation program ordered by the Referee. Furthermore, we conclude that the Director correctly determined that claimant was not eligible for vocational assistance.

Claimant's proven ability to perform gainful employment for more than two years after returning to work post-injury demonstrates that he is not a vocationally handicapped worker within the meaning of the administrative rules in effect at the time of his injury. Cf. Frame v. Crown Zellerbach, 63 Or App 827, adhered to on reconsideration, 65 Or App 801 (1983). Nor would claimant be considered a "vocationally displaced worker" under the rules in effect at the time of his injury, the definition of such a worker then being "one who is not a vocationally handicapped worker but who requires employment reentry assistance to return to gainful employment." Former OAR 436-61-005(12).

Claimant testified that he resigned from his school district employment because of his back condition. However, we conclude that the remainder of the record rather clearly establishes that,

although claimant continued to experience symptoms of low back pain, his reasons for leaving his school district employment in 1982 were not directly related to his 1979 back injury. He worked as a janitor for the school district for over one year. He stopped working because of a finger injury, not because of his low back condition. Claimant resigned in 1982, in lieu of being discharged, for reasons which were only partly, and very indirectly, related to his 1979 industrial injury. Before working for the school district, claimant had been regularly employed but was terminated for reasons totally unrelated to his industrial injury.

Regardless of which rules apply, the Director's decision should be upheld for the simple reason that claimant is not presently unemployed as a result of his industrial injury. A worker who has proven his post-injury ability to obtain and hold gainful employment is not in need of services to restore his or her earning capacity. See ORS 656.012(2)(c), 656.268(1). There is no persuasive evidence indicating that claimant is no longer capable of performing the light duty or janitorial work he has performed since recovering from his industrial injury. It may well be that "it would be nice" if claimant could be retrained, as indicated by his physician, but the injured workers for whom retraining is a matter of necessity, as opposed to merely a nicety, are legion; and the resources available for providing vocational assistance are increasingly finite.

We believe that claimant is a well-motivated individual who is to be commended for his past successful efforts in obtaining employment suitable to his physical limitations. We are unable to conclude, however, that claimant has established entitlement to vocational assistance in connection with his industrial back injury.

ORDER

The Referee's orders dated April 29, 1983 and July 19, 1983 are reversed. The decision of the Director of the Workers' Compensation Department dated February 3, 1983 is reinstated and affirmed.

HOWARD RICE, Claimant
Richard Condon, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 82-07181
September 18, 1984
Order of Abatement

The Board has received the employer's motion for reconsideration of our Order on Review dated August 20, 1984.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

GLENN L. GOSSLER, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Brian Pocock, Defense Attorney

WCB 83-06754 & 81-03060
September 19, 1984
Interim Order of Dismissal

Aetna Technical Services has moved to dismiss the SAIF Corporation's request for review.

Aetna contends that SAIF did not mail a copy of the request for review to either Aetna, its insured or its attorney and that none of the above three received actual notice of the request for review within 30 days of the Referee's order. Thus the requirements of ORS 656.295 and Argonaut v. King, 63 Or App 847 (1983) were not satisfied. The record supports Aetna's contention. Accordingly, SAIF's request for review is dismissed.

However, the Board is not thereby deprived of jurisdiction over this case because claimant filed a cross request for review within 30 days of the Referee's order. No party argues that it did not receive adequate notice of claimant's cross-request for review. Accordingly, the Board continues to have jurisdiction over this case as a result of claimant's cross-request for review.

In Jimmie Parkerson, 35 Van Natta 1247 (1983), we faced a similar situation. In Parkerson we dismissed a cross-request for review because of lack of notice to all parties. However, we said:

> "[T]he consequence of dismissal . . . is of limited significance. There is no requirement that a party cross-request review in order to have particular issues considered on de novo review. [citations omitted] There are no specific pleading requirements in proceedings before the Board. A party may file a request for review of a Referee's order simply by a statement that review is requested. ORS 656.295(1). Most often the issues to be reviewed are not defined until the appellant has filed its brief with the Board. Where a respondent files a brief making an argument or raising an issue which diverges from those raised or argued in the appellant's brief, we consider the additional argument or issue even in the absence of a cross-request for review." 35 Van Natta at 1249-50.

Because we are dismissing SAIF's request for review, we treat claimant's cross-request as the original request for review. Thus, technically, claimant is the appellant and both SAIF and Aetna are respondents. SAIF has already filed briefs which it labels "appellant's brief" and "appellant's reply brief". Claimant has filed a brief which he entitles "Respondent's brief and Brief on Cross Review". Aetna has filed no brief. Aetna is now allowed 30 days in which to file a brief responding to issues raised by either SAIF or claimant. Claimant may file a reply brief within 10 days of Aetna's brief. At that time the case will be docketed for Board review.

ORDER

The SAIF Corporation's request for review is dismissed. The Board retains jurisidiction over this claim because of claimant's timely cross-request for review. Processing shall continue consistent with this order.

MARVIN E. PETERSON, Claimant
Steven C. Yates, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 83-10708
September 19, 1984
Order of Dismissal

On July 31, 1984 the Referee issued her Opinion and Order herein. On August 22, 1984 the Board received claimant's request for reconsideration. On August 27, by letter directed to the parties, the Referee refused to reconsider her Opinion and Order. On September 5, 1984 the Board received claimant's Notice of Appeal of the Opinion and Order. The appeal is not timely and must be dismissed. ORS 656.289(3).

IT IS SO ORDERED.

TIMOTHY L. BLAIR, Claimant
Welch, et al., Claimant's Attorneys
Cheney & Kelley, Defense Attorneys

WCB 82-10499
September 21, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The insurer requests review of those portions of Referee Danner's order which: (1) set aside its partial denial of claimant's temporomandibular joint dysfunction (TMJ); (2) found that the TMJ condition causes headaches which are disabling to claimant; and (3) found that the November 1982 partial denial and part of the June 1983 partial denial were unreasonable and thus assessed a penalty against the insurer. Claimant cross-requests review of that portion of the Referee's order which upheld the insurer's partial denial of his visual problems.

Although, as our opening summary may indicate, this claim has become rather complex, it began in a more simple manner when claimant, a long haul truck driver, was involved in a truck accident in May 1980. The details of that accident are somewhat vague and disputed to some extent. Apparently the brakes in claimant's truck gave out while he was descending a steep grade in the Siskiyou Mountains in southern Oregon, and claimant was forced to utilize an escape ramp where, according to his testimony, the truck eventually struck a retaining wall. In any event, there was sufficient trauma involved at that time that claimant suffered a T-11 compression fracture, a right wrist fracture and a right rib fracture. He was hospitalized for four days.

More than two years after the truck accident, in October 1982, Dr. Gordon, an osteopath, first reported that he was treating claimant for TMJ, headaches and emotional disturbances, all of which he thought were a result of the 1980 truck accident. Dr. Gordon was apparently trying to realign claimant's jaw through physical manipulation, which apparently was unsuccessful; he eventually referred claimant to an oral surgeon in October 1982. The oral surgeon, Dr. Springer, also diagnosed TMJ.

We understand the issues of the compensability of claimant's TMJ, the compensability of his headaches and whether either or both conditions are disabling to really present a single issue. All doctors seem to agree that the TMJ causes the headaches, and most doctors generally agree that the headaches are disabling. The dispute thus centers on the TMJ itself.

Claimant contends that his TMJ is a compensable consequence of his truck accident. Claimant's theory is that, during the accident, he was thrown around in the truck cab and sustained injury to his head/face/jaw/neck at that time. There is medical support for this theory in the sense that several doctors opine that, if there was such head trauma, it could cause TMJ. There is circumstantial support for this theory in the sense that we know the truck accident was sufficiently traumatic to cause various broken bones. Claimant explains the gap of about two years between the injury date and the diagnosis date by reliance on medical literature that states that TMJ symptoms may go undiagnosed for a considerable length of time before the cause is discovered.

At the request of the insurer, claimant was examined by Dr. Rohlfing, an oral surgeon, who also reviewed most of the prior medical reports. Dr. Rohlfing opined that claimant's TMJ condition was not related to the truck accident, primarily because the medical reports from just after the 1980 truck accident indicated no loss of consciousness and no injury to the face or head. The predicate of Dr. Rohlfing's opinion is fully supported by this record. The 1980 medical reports do not indicate any head, face, neck or jaw injuries or record any complaints of pain in these areas; on the contrary, all mention of the head/neck area indicates normal examination findings.

The doctors who say that head or jaw trauma can cause TMJ are, unfortunately, rather vague about the amount and nature of trauma that is necessary. To find their opinions persuasive in this case, we would have to be able to conclude that the quantity and quality of necessary trauma is something less than could be detected by several doctors who examined and treated an injured driver who was hospitalized for four days following a truck accident. We are unable to so conclude. We think the 1980 reports of normal head/neck examination findings make it impossible to now conclude that there was 1980 head trauma that was sufficient to cause a jaw condition that was first diagnosed about two years later.

On the issue of the compensability of claimant's vision problems, we affirm and adopt the relevant portions of the Referee's order. On the penalty issue, since we have found the insurer's partial denials of claimant's TMJ and vision problems to be correct, we certainly cannot agree with the Referee that there was anything unreasonable about these denials. The insurer's partial denial dated June 13, 1983 may have been overbroad as written; but, as it has been litigated, the possibly overbroad portion has properly been ignored and only the vision loss matter has been contested.

Finally, we understand claimant to have raised the issue of extent of disability which the Referee did not reach because of his ruling on the compensability of claimant's TMJ. With the

understanding that an alternative extent issue was raised, we deem it appropriate to remand this case for further proceedings on that issue.

ORDER

The Referee's order dated July 14, 1983 is affirmed in part and reversed in part. That portion of the Referee's order that set aside the insurer's partial denial dated November 10, 1982, with regard to claimant's temporomandibular joint syndrome, is reversed and, in lieu thereof, that partial denial is reinstated and affirmed. That portion of the Referee's order that assessed a penalty and awarded an attorney fee is reversed. The remainder of the order is affirmed. This case is remanded to the Hearings Division for further proceedings consistent with this order.

Board Member Barnes Concurring:

There is a line of reasoning in the Referee's order that I believe is fundamentally wrong, although it is a line of reasoning that is rather common in Oregon workers compensation cases.

The Referee states that claimant's appearance at hearing was "completely inconsistent with his allegations, and those of Dr. Gordon, that he is unable to do any type of work."

The Referee states: "It is very difficult, and stretches credulity, to percieve [sic] that the TMJ condition . . . could cause this claimant to be totally disabled." (Emphasis in original.)

After noting that Dr. Gordon opined that "unless [claimant's] jaw is repaired, he will be totally and permanently impaired from any gainful occupation," the Referee states that he finds "Dr. Gordon's statement difficult to accept."

So far, so good. The Referee has articulated reasons, well grounded in common sense and common experience, why he might not be persuaded by some of the evidence. However, the Referee then falls into the all-too-common, methodological error: "I have no choice, however, but to accept it [i.e., evidence that flies in the face of common sense], there being no evidence contra."

Referees, Board members and Court of Appeals judges will likely persist in this flawed approach in workers compensation litigation regardless of anything I say; but I take this opportunity to state that I wish that the factfinders at all levels of this litigation system had a more complete and more accurate appreciation of what it means to be a factfinder -- which clearly does not mean that we must find nonsense persuasive just because it is uncontradicted.

EULA L. CROWE, Claimant
Rolf Olson, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 82-06883
September 21, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer, Jeld-Wen, Inc., requests review of Referee Quillinan's order which set aside its denial of claimant's aggravation claim of her 1979 low back strain. The employer contends, and indeed the Referee's findings of fact show, that claimant's later employment for Klamath County contributed to the worsening of her condition and, therefore, Jeld-Wen, Inc. should no longer be the responsibile employer and that the responsibility should shift to Klamath County.

At the time of the Referee's interpretation of the rules of law in responsibility cases, the opinion of Boise Cascade v. Starbuck, 61 Or App 631 (1983), was the law in effect. The Referee interpreted that case to not allow a shifting of responsibility to a later employer unless claimant was able to identify a particular, traumatic incident in her work at Klamath County which could have worsened her low back pain. Since the Referee's order, the Starbuck case has been amplified in the Supreme Court's opinion in Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). A reading of the Supreme Court's opinion shows it is not necessary that there be a definite identifiable incident to shift responsibility to a later employer. There must only be evidence of work conditions which actually contributed to the disability. In this case there is such evidence and, therefore, the responsibility should shift to Klamath County.

Claimant was initially injured in April 1979. She suffered a reinjury in August 1979. Her condition was diagnosed as lumbosacral strain with possible herniated disc. Claimant experienced low back pain and some right leg symptoms. However, a myelogram and EMG studies were read as negative. By March 1980 Dr. Campagna, claimant's treating doctor, reported that claimant was doing well and had an excellent recovery. However, claimant continued to complain of pain and Dr. Campagna did note some pain in her low back and pain and numbness in her right leg. The claim was closed with an award of temporary disability benefits but no permanent disability benefits.

Claimant left Jeld-Wen and became employed with Klamath County in the Building Maintenance Department. Claimant worked primarily as a painter for the maintenance department. This involved considerable bending, stooping, stretching, lifting and carrying. Claimant temporarily quit work on March 16, 1982 and quit entirely on April 2, 1982 due to increasing pain. She saw no doctors in the intervening period between July 1980 and March 1982.

Dr. Campagna felt that claimant's original low back injury had worsened but he also felt that claimant's work activity for the County contributed at least in part to her back problem. According to claimant, her low back pain never subsided or went away for any length of time throughout the two years she worked for the County. About two months after she began employment there, her back pain became more constant and she missed some time from work due to her back problems. About six months before she quit the County, she asked to be transferred to a clerical

position. Two months before her resignation she further indicated to the personnel manager that her back was becoming worse and that she could not stay in her present job. Claimant complained constantly about her back to her immediate supervisor at Klamath County and claimant did lose time from work at Klamath County due to those problems at the rate of approximately five to six days per month.

We find that the medical opinion and circumstantial evidence above shows that claimant's employment with Klamath County did contribute to her disability.

ORDER

The Referee's order dated September 19, 1983 is reversed in part. The employer's denial of June 22, 1982 of claimant's aggravation claim is approved. Accordingly, claimant's attorney shall not be awarded an attorney fee for prevailing on the issue of compensability. The remainder of the Referee's order is affirmed.

HELEN L. DODGE, Claimant
Coons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-03201 & 82-09119
September 21, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Quillinan's order which: (1) set aside its denial of claimant's psychiatric condition; (2) set aside its denial of claimant's weight loss program; (3) awarded claimant's attorney a fee equal to $2,000 for prevailing on the above denials; and (4) assessed SAIF a penalty of $350 for its failure to accept or deny the July 1982 aggravation claim within 60 days. Claimant cross-requests review of those portions of the order which: (1) affirmed SAIF's denial of aggravation claims stemming from claimant's hospitalizations in January 1982 and July 1982; and (2) failed to award claimant interim compensation together with penalties and a separate attorney fee for SAIF's unexplained failure to accept or deny claimant's July 1982 aggravation claim until the date of the second hearing in this case, on October 13, 1983.

We reverse those portions of the Referee's order which set aside SAIF's denial of claimant's weight loss program and which awarded a penalty and attorney fee for the late denial. We modify that portion of the Referee's order which awarded claimant's attorney a $2,000 attorney fee for prevailing on the issue of psychiatric treatment.

Claimant is five feet three and one-half inches tall and has weighed over 200 pounds for many years, including the date of her low back strain on September 22, 1977. Claimant's doctors have recommended since the inception of her injury that she lose weight as a way of treating her low back strain. However, claimant has been mostly unsuccessful in her weight reduction programs. We have held that where a claimant's obesity preexists the compensable injury and the obesity was not caused or worsened by

that injury, the workers' compensation system is not responsible for the medical treatment to treat the obesity. Mark G. Blanchard, 34 Van Natta 1660 (1982); Neal D. Maloney, 36 Van Natta 1071 (July 12, 1984). There is no evidence in this case that claimant's preexisting obesity was worsened by her low back strain and, therefore, her doctor's recommendation for a weight loss program is not the responsibility of the SAIF Corporation.

With regard to SAIF's failure to deny claimant's July 1982 aggravation claim until October 1983, we find we must reverse the Referee's award of a $350 penalty and the accompanying $350 attorney fee because there are no amounts due by reason of the late denial upon which a penalty may be based. ORS 656.262(10).

Claimant's argument that she is entitled to interim compensation from the notice of the claim to the date of denial is apparently based on the court's holding in Bono v. SAIF, 66 Or App 138 (1983). However, the facts in Bono did not involve an aggravation claim, such as is the case here. ORS 656.273(6) requires only that interim compensation be paid no later than the fourteenth day after the employer has "notice or knowledge of medically verified inability to work resulting from the worsened condition." There is no evidence in this case of claimant's medically verified inability to work between July 1982 and October 1983 due to a worsened condition, therefore, no interim compensation is due over that time period.

Finally, we modify that portion of the Referee's order which awarded claimant's attorney $2,000 for prevailing on the issue of the compensability of claimant's psychiatric condition (depression). Although there were two hearing appearances required in this case which stretched the proceedings out over a year's time, it does not appear that this case otherwise required efforts on the part of claimant's attorney that were in excess of those generally required. Taking into account our reversal of that portion of the Referee's order which set aside the insurer's denial for claimant's weight loss program, we find that a more appropriate attorney fee for claimant's attorney's efforts in this case to be $1,500.

ORDER

The Referee's order dated November 8, 1983 is reversed in part, modified in part and affirmed in part. We reverse those portions of the Referee's order which set aside the SAIF Corporation's denial of claimant's weight loss program and which assessed a penalty and attorney fee for failure to accept or deny the July 19, 1982 aggravation claim within 60 days. We modify that portion of the Referee's order which awarded claimant's attorney $2,000 for prevailing on the issue of the compensability of claimant's psychiatric condition by reducing that amount to the sum of $1,500. The remainder of the Referee's order is affirmed.

RALPH D. HICKMAN, Claimant
Michael Dye, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 83-06029
September 21, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

The insurer requests review of Referee Podnar's order which directed it to recalculate the rate of temporary total disability compensation payable to claimant and pay compensation based upon a weekly wage of $366. The issue is the rate of temporary total disability compensation payable to this "on call" employe. See ORS 656.210; OAR 436-54-212(3). A secondary issue raised by claimant concerns the propriety of the Referee's evidentiary ruling excluding the testimony of a witness offered by claimant.

On the merits of the time loss issue, we affirm the Referee's order. With regard to the evidentiary issue raised by claimant, we agree with claimant that the witness' testimony should have been admitted and considered by the Referee; however, we conclude that the error is harmless.

ORDER

The Referee's order dated January 13, 1984 is affirmed. Claimant's attorney is awarded $700 for services on Board review, to be paid by the insurer.

BRUCE E. JARRETT, Claimant
Garry Kahn, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 82-09847
September 21, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Referee Knapp's order which set aside its denial of aggravation of claimant's low back condition. The insurer contends that surveillance films taken of claimant over a two day period clearly show a discrepancy between claimant's reported limitations due to his low back and his actual level of activity and, therefore, that claimant's testimony and medical opinions based on those reports must be discounted. Further, the insurer contends that the remaining objective evidence of a bulging disc is insufficient in light of claimant's lack of credibility to prove that his low back condition has worsened since his last award of compensation. We agree with the insurer and reverse.

Claimant was injured in September 1978, then 23 years of age, while working as a welder for the employer. Dr. Kiest, orthopedic surgeon, became his treating doctor at that time and felt that claimant herniated a disc involving the L4-5 level on the left side of the low back. However, all objective tests were normal. Claimant was treated conservatively and eventually entered a program of vocational rehabilitation.

Claimant received a Determination Order in June 1979 which awarded him 10% unscheduled permanent partial disability benefits. His case was reopened later in 1979. A myelogram was performed and found to be normal. A second Determination Order was issued in March 1980 which awarded no additional permanent

disability benefits. However, by Opinion and Order of July 1980 claimant was awarded an additional 25% unscheduled permanent disability benefits for a total of 35%. That was the last arrangement of compensation. At the time of that award, claimant related that, because of his back problems, he could not sit for more than an hour or two, had sharp pains if he exercised, had to lie down in his classroom for relief, did his homework lying down, had to quit playing baseball, running, water skiing and tennis and had to limit his swimming exercises. Dr. Van Osdel, of the Callahan Center, imposed limitations on claimant that limited him to not lifting over 50 pounds on a one time basis, not lifting over 25 pounds repetitively and avoiding repetitive crawling, twisting, stooping, pushing or pulling. Dr. Kiest also restricted claimant from repetitive bending, lifting or twisting.

Claimant returned to see Dr. Kiest in March 1982 complaining about increased back pain. Dr. Kiest prescribed a gravity traction device but did not request reopening of the claim. Claimant next saw Dr. Kiest on July 27, 1982 with complaints of back and left leg pain at which time Dr. Kiest requested reopening for a short period of time in order that a CT scan could be performed. The August 2, 1982 CT scan of the lower back revealed a slight assymetry at L4-5 on the right and a slight assymetry at L5-S1 on the left. There was slight posterior displacement of the nerve root at the L4-5 level but no displacement at the L5-S1 level. Dr. Kiest did not recommend further treatment as claimant's condition seemed to be improving. However, by September claimant reported increased back pain with radiation into his legs and Dr. Kiest felt claimant could not work and requested another myelogram.

The employer had claimant seen by the Orthopaedic Consultants on September 20, 1982. Claimant complained of constant low back pain made worse by bending, sitting more than 15 minutes, lifting more than 15 pounds, coughing, twisting, walking or riding in the car. Claimant described sharp shooting pains brought on by fast jerky movements and lifting. The Orthopaedic Consultants panel diagnosed chronic lumbar strain and felt claimant was medically stationary and that his condition had not deteriorated since June 1980 (the last arrangement of compensation). The Orthopaedic Consultants noted that although claimant claimed a material worsening of his condition since June 1980, this was not borne out by the examination. They noted the CT scan report that discussed certain abnormalities; however, they noted that the abnormalities were referred to as being only slight: "He has no clinical [sic] correlates with the scan abnormality. There is no evidence by x-ray of continuing degenerative disc disease. In summary, I do not feel the 'abnormal' CT scan has a clinical significance to the point of warranting a myelogram or surgery."

On October 1, 1982 the aggravation claim was denied. Dr. Kiest is critical of the denial stating that he had been caring for claimant for over four years and had numerous opportunities to operate on claimant but had not because claimant had a great deal of patience and forebearance and was not "knife happy": "This man is finally getting to the point where he cannot function and is not only requesting, but pleading for, surgical treatment."

Meanwhile claimant's activities were being observed by the

insurer. Video tapes taken on September 23 and 24, 1982 show claimant working for five hours the first day and again for an hour the second day on his pickup truck using a hydraulic jack, kicking a tire with both feet, using tools such as wrenches and a hammer and performing many repetitive tasks such as bending, squatting, twisting and lying under the pickup without signs of limitation or pain. Clearly, these activities were not in keeping with claimant's reported limitations to the Orthopaedic Consultants or Dr. Kiest.

The employer had claimant examined by Dr. Post on December 8, 1982. Although Dr. Post found lumbar extension only to 50% of normal and flexion to 70% of normal, he also found that straight leg raising was 80° on both sides with negative tests for sciatic irritability. Bent leg testing was possible to 130° on both sides. There was no ascertainable weakness in the lower extremity. The pattern of hyperthesia did not correspond with any sensory dermatome and represented to Dr. Post a "functional variant." Dr. Post did not find the CT scan findings to be significant and felt that "this patient really does not satisfy any of the criteria for disc extrusion." Dr. Post stated that claimant may possibly be exhibiting some restriction of forward motion as compared to his condition in 1980, but he was not really able to say that that represented a material worsening because there had only been insignificant changes. He noted that claimant believed that his condition was distinctly worse and, it was Dr. Post's impression, that claimant was not "seeking any variety of legal regress [sic] but only medical help, if possible."

Next, Dr. Raaf, neurosurgeon, reviewed claimant's medical file and concluded that the CT scan relied on by Dr. Kiest was inconclusive at best. Dr. Raaf's conclusion was that neither claimant's history nor examinations indicated that he had a herniated disc as the cause of these symptoms. He noted that the December 1979 myelogram was normal and that the CT scan done in August 1982 was not convincing that an operable herniated disc was present. Dr. Raaf agreed with the Orthopaedic Consultants' report and was in complete agreement with their conclusions.

Subsequent to Dr. Raaf's report, the employer agreed to allow claimant to again be tested by myelogram and to pay time loss for the hospitalization associated with it. The myelogram was scheduled subsequent to the hearing and the results of that test are not contained in this record. At hearing, claimant testified that since August 1982 he had lived like a hermit, remaining in bed to read the paper, watch TV and do homework. He said that sitting for even 15 minutes would cause his back to hurt. Claimant testified that, other than attending Portland Community College from August 1982 through January 1983, he really was unable to do any other activity except getting kindling for the stove. He stated that just to bend over to pick something up caused his back to be out for a day or two. He denied kicking at the wheels of his truck or performing any major work on it. He stated that he had not done any twisting or turning since August 1982. As mentioned earlier, the surveillance films taken in September 1982 showed claimant's testimony to be false.

After making a thorough review of all the evidence, the Referee determined that the positive CT scan finding in August

1982, together with Dr. Kiest's opinion as the treating physician, proved that claimant's condition has worsened since June of 1980. Although the Referee was well aware of claimant's unreliability in reporting his back condition and its limitations, he felt that there was sufficient medical evidence to prove the worsening without claimant's testimony.

Although we recognize that Dr. Kiest was in a superior position to judge whether claimant's condition had worsened, we also note that the basis for his judgment in large part was that of claimant's representations to him regarding pain and limitations due to his low back injury. It does not appear from the persuasive medical opinion that the CT scan is enough evidence from an objective standpoint to prove that claimant had suffered a worsening of his condition since June 1980. Claimant has mentioned other minor objective signs of worsening such as a three-eighths of an inch difference in circumference between claimant's right and left leg. No doctor found these differences significant enough in themselves to show that claimant had suffered a worsening.

Finally, given the film evidence showing claimant's ability to perform heavy work, including repetitive bending, twisting, stooping, etc., within days of his report to his treating doctor, Dr. Kiest, that he was hurting so much that he was unable to go to work and was asking for surgery, we are unable to place as much confidence in claimant's history as does Dr. Kiest. On that basis, and lacking more definite objective medical evidence, we find that the employer's denial of October 1, 1982 should be approved.

ORDER

The Referee's order dated February 18, 1983 is reversed. The employer's denial dated October 1, 1982 is reinstated and affirmed.

SMITTY R. MARTINO, Claimant
Gatti & Gatti, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-07594
September 21, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Peterson's order which awarded claimant 64° for 20% unscheduled disability for injury to the neck and upper back. SAIF contends that claimant has failed to establish that he suffers any permanent disability as a result of this industrial injury.

Claimant sustained this injury to his neck and back when, in the course of his employment as a psychiatric aide at Fairview Hospital and Training Center, he was assisting a paralyzed resident out of a bathtub, the resident began to fall, and claimant caught the resident in order to break his fall. Claimant immediately experienced the onset of pain in his neck and shoulder blade area. Claimant had no prior injuries to his neck, shoulder or back. Dr. Bolin, a chiropractic physician, diagnosed lower cervical, mid thoracic and lumbosacral strain. Dr. Bolin reported that no impairment was expected to result.

Claimant began treatment with a different chiropractor, Dr.

Grobman, who diagnosed cervical strain with radiation of pain and paresthesia down the left arm. Dr. Grobman released claimant to modified work in early January of 1983, with the restriction of no repeated lifting over 30 pounds. Claimant returned to work as a monitor.

Dr. Grobman referred claimant for examination to Dr. Buza, a neurosurgeon, who stated a diagnosis of cervical strain. Dr. Buza believed that claimant should continue treatment with Dr. Grobman.

Claimant worked in the laundry room at Fairview for a while, but this work apparently caused him physical distress. On February 28, 1983 Dr. Grobman reported that the laundry duty was too strenuous for claimant, and that he should return to monitor duty.

Claimant was reexamined by Dr. Bolin on June 10, 1983, and in a report of that examination, Dr. Bolin stated that claimant had responded well to chiropractic treatment with a slow and gradual improvement. He found a very minimal residual impairment in the lower cervical spine requiring an occasional palliative treatment over the next three to four month period. No functional overlay was noted.

On July 26, 1983 Dr. Grobman reported that claimant had limitations in the form of restricted ability to engage in heavy lifting and repetitive lifting above his shoulders. He stated that, as a result of these restrictions, claimant had sustained a minimal partial disability. He also reported that on June 14, 1983, four days after Dr. Bolin's examination, claimant had sustained another injury to the same area, and that this recent incident had hindered his recovery and increased the number of treatments needed. Dr. Grobman indicated that this recent episode was not a "permanent setback."

A Determination Order closed the claim on August 4, 1983, awarding temporary disability and no permanent disability.

Claimant testified that he continues to experience stiffness in his neck, occasional headaches, numbness of his left arm and some pain in the shoulder blade area. Since October of 1983, claimant has been working at Fairview, and his current job duties include washing, drying and storing underclothes, as well as charting, cleaning bathrooms, sweeping and mopping. This job involves very little heavy lifting, other than lifting mop buckets. Claimant considers his present employment as "much lighter duty work" than his former job, which included lifting adult residents on a daily basis.

Claimant is restricted in his ability to perform physical activity of which he was capable prior to this industrial injury. SAIF argues that if claimant has sustained any permanent impairment, it results from the more recent June 19, 1983 incident (which apparently has been accepted by SAIF as a new injury) rather than this 1982 injury; however, when Dr. Bolin examined claimant four days before this incident, he found some residual impairment, although it was "very minimal." We conclude that claimant is entitled to an award for permanent partial disability, but we find that the Referee's award was excessive.

Claimant was 45 years of age at the time of hearing. He has

a formal tenth grade education and received a GED while in the Army. He has worked for Fairview Hospital for seven years, and he previously worked for Boise Cascade for 12 years as an offbearman. Other than his certification as a psychiatric aide, claimant has no other special training or skills.

In view of the restrictions imposed by claimant's treating physician, we conclude that his residual functional capacity is for work in the medium category. The evidence of record establishes that claimant's pre-injury employment as a psychiatric aide was heavy work. See OAR 436-65-605.

In consideration of all these factors, and comparing this case to other cases involving similarly situated injured workers, we find that an award of 32° for 10% unscheduled disability appropriately compensates claimant for the loss of earning capacity attributable to this industrial injury. We modify the Referee's order accordingly.

ORDER

The Referee's order dated January 27, 1984 is modified. In lieu of the 64° for 20% unscheduled disability awarded by the Referee, claimant is awarded 32° for 10% unscheduled disability for injury to his neck and upper back.

EVERETT E. ROBINSON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08760
September 21, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Quillinan's order which: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim; and (2) upheld the SAIF Corporation's denial of authorization for an ankle fusion procedure recommended by claimant's treating physician. The issues are whether claimant has established a worsening of his condition since the last award of compensation, and whether the proposed ankle fusion is reasonable and necessary within the meaning of ORS 656.245. As an alternative remedy, claimant requests that the Board remand to the Referee for further evidence taking.

On the issue of SAIF's denial of claimant's aggravation claim, we affirm and adopt the relevant portions of the Referee's order. We remand to the Referee for further proceedings on the issue of the proposed ankle fusion procedure.

Claimant sustained this industrial injury in December of 1978. While working as a ranch hand, he fractured his right ankle. He sustained a spiral fracture of the distal fibula. He initially was treated in the emergency room, where a cast was applied. He came under the care of Dr. Poulson, who removed the cast a few days later and treated him with bandaging. Reduction of the fracture was not necessary. Dr. Poulson released claimant to return to work in March 1979, and the claim was thereafter closed with an award for temporary total disability only.

Claimant returned to work, working for a trailer factory. After six months claimant was unable to continue working because of increasing ankle symptoms. He came under the care of Dr. Paluska, who diagnosed an entrapment of the sural nerve of the right ankle. Conservative measures, including casting, were initiated with no improvement. In January 1980 Dr. Paluska performed neurolysis of the sural nerve, the first in a series of operative procedures.

This surgery may have afforded some temporary relief; however, as of the latter portion of March 1980, claimant was complaining of pain with weightbearing, which prompted Dr. Paluska to perform an ankle arthrogram. There was no evidence of any loose body within the ankle joint, and the articular surface was normal. In April 1980 Dr. Paluska reported that claimant's range of ankle motion was normal, and that he did not anticipate any permanent problem because of the injury "or this series of events which followed." The claim was again closed by a Determination Order awarding compensation for temporary total disability only.

In August 1980 claimant came under the care of Dr. Martens, who diagnosed a possible tarsal tunnel syndrome of the right ankle and referred claimant for a neurologic consultation with Dr. Throop. Dr. Throop confirmed the diagnosis and stated that claimant was in need of decompression of the tarsal tunnel in order to alleviate his complaints of numbness and radiating pain. Dr. Throop stated, however, that this procedure might not alleviate claimant's deeper pain and recurrent ecchymosis.

Dr. Martens requested and received authorization to perform decompression of the posterior tibial nerve at the right tarsal tunnel, which was accomplished in November 1980. This surgery reportedly alleviated symptoms on the medial aspect of claimant's ankle. Three months after surgery, however, claimant was continuing to experience swelling of the ankle, a burning sensation in the heel of his foot and discoloration. Dr. Martens began to suspect some nerve entrapment, although he did not believe claimant would benefit from further exploration of the sural nerve. He recommended an independent orthopedic evaluation.

Claimant then was examined by Dr. Fry in May 1981, who stated his impression that surgical reexploration was warranted in view of claimant's continuing symptomatology. Dr. Martens requested authorization for exploration of the lateral malleolar area of the right ankle. Neurolysis of the sural nerve was again performed in December 1981. Claimant subsequently developed an infection in the incision, which resolved with treatment. This surgery apparently alleviated claimant's symptoms on the outer aspect of his ankle for a short period, but the symptoms eventually returned.

Claimant was released for medium work in late January 1982. Restrictions noted were prolonged standing, walking, running, jumping or climbing stairs. His claim was reclosed by Determination Order in March 1982, which awarded temporary total disability and 13.5° scheduled disability for a 10% loss of the right foot (ankle). The permanent disability award was increased by the parties' June 17, 1982 stipulation, which granted claimant a total scheduled award of 31% (41.85°).

X-rays in July 1982 indicated that the fracture had healed and that no other changes had occurred. Claimant continued to

experience pain, however, and a TNS unit was tried unsuccessfully. A September 22, 1982 office note entry by Dr. Martens states:

> "All conservative measures have given no relief of the pain. I have discussed with him the severity of the pain. I have no way to measure pain. If the pain becomes too severe he may want to consider an ankle fusion, however before this is considered, he should have immobilization of the right ankle in a cast."

Dr. Martens applied a plastic or fiberglass short leg cast in late October of 1982 in order to determine whether immobilization would relieve the pain.

A December 8, 1982 office note entry by Dr. Martens indicates that, for the preceding six weeks while claimant had worn the short leg cast, his ankle was "the best it ha[d] ever been." Claimant decided to undergo ankle fusion surgery. A subsequent office note entry indicates claimant's impression that the short leg cast relieved 90% of his ankle pain. Dr. Martens requested authorization for the ankle fusion procedure.

SAIF referred claimant's request for authorization to Dr. Embick. After reviewing claimant's medical records, Dr. Embick stated his disagreement with the proposed fusion. Dr. Embick noted that the fracture had healed well; that, although claimant had experienced pain and decreased sensation along the lateral and medial aspects of the ankle joint, he had no specific ankle joint pain; and that three operations had been performed essentially with no benefit. Dr. Embick found no evidence of arthritic changes, instability or serious motion loss to warrant the proposed surgery. He recommended an independent medical examination by Orthopaedic Consultants, and this was obtained in January 1983.

After examining claimant, reviewing his medical history, and obtaining new x-rays, the Consultants stated several diagnoses, including continuing right ankle pain brought on by mechanical irritation. Their report states in part:

> "After careful evaluation of this patient and his x-rays, I would be reluctant to recommend ankle fusion. I think that the indication should be stronger. There should be more evidence of a significant traumatic arthritis or joint surface damage. With these findings, there is always the possibility that an ankle fusion will end up producing reduced motion of the ankle without relief of pain. Thus, it would be unfortunate to have this man go through an extensive operative procedure and long-term casting and end up with as many symptoms as he has now."

The Consultants noted that claimant seemed to have an unrealistic

expectation concerning the results of surgery. "Seemingly, [he] is of the opinion that surgery will provide 100% relief of pain. This probably never occurs with an ankle fusion; although fusions are certainly indicated in cases where the joint surfaces are severe[ly] damaged."

The Consultants did not entirely rule out the prospect of an ankle fusion. They were clearly of the opinion, however, that other procedures and forms of conservative treatment should first be attempted. They recommended a molded, leather ankle brace, which they felt would afford the same support as a cast and which could be removed at night. Other diagnostic procedures, such as an arthrogram, were recommended. In addition, injection of the joint with local anesthetic was suggested.

Dr. Martens subsequently reviewed the Orthopaedic Consultants' report and stated his agreement with their comments and recommendations. In fact, Dr. McKillop of the Orthopaedic Consultants panel had phoned Dr. Martens on the date of their examination in order to discuss their recommendations.

In February 1983 claimant began a trial with a molded fiberglass short leg brace. Dr. Martens' office note entry indicates that the brace did not support the ankle as well as the cast had.

On February 15, 1983 Dr. Martens administered a cortisone injection, which gave relief for only six or seven hours, after which claimant experienced increased pain and found it necessary to use crutches for several days. A March 2, 1983 office note entry by Dr. Martens indicates that the molded short leg brace was not relieving claimant's pain. There apparently was a problem with obtaining a proper fit.

An ankle arthrogram was performed on March 4, 1983. The results were negative.

As of March 16, 1983, claimant had stopped wearing the short leg brace because he could not get a comfortable fit. He was fitted with a canvas ankle splint. An April 27, 1983 office note entry by Dr. Martens indicates that the canvas ankle splint did not afford as much relief of the ankle pain as the short leg brace, and that claimant would prefer a short leg cast. Dr. Martens explained that he did not recommend a cast as a prolonged treatment method.

The most recent information from Dr. Martens is a May 25, 1983 office note entry indicating that claimant's examination was essentially unchanged. Claimant was requesting pain medication, which Dr. Martens refused to prescribe. He indicated that claimant should take nothing more than aspirin or Tylenol.

At the hearing on June 14, 1983, claimant and his wife described claimant's continuing pain problem, including the fact that claimant's ankle would periodically give way, causing him to fall.

On March 16, 1983 Dr. Martens had reported to SAIF as follows:

"I have nothing further to offer Mr.

> Robinson at this time other than ankle fusion. He states he had had the most relief of his right ankle pain when a short leg walking cast was applied. Therefore, I suggest he have an independent orthopedic evaluation regarding further treatment."

This is a difficult case. On the one hand, there is the distinct possibility that if the ankle fusion is performed, claimant will continue to experience a significant pain problem notwithstanding surgery. Although relief of claimant's pain is speculative, it is a certainty that a fusion will result in a significant loss of motion, and consequently function, of the ankle joint. Neither Dr. Embick nor the Orthopaedic Consultants seemed particularly convinced that, just because the short leg walking cast afforded claimant significant relief of his symptoms, an ankle fusion would produce the same result. These physicians appear to be of the opinion that objective findings, such as advanced arthritic changes in the joint, or significant joint surface damage, should be present in order to warrant this proposed surgery.

On the other hand, Orthopaedic Consultants has not entirely ruled out the prospect of a fusion, and they are clearly of the opinion that additional conservative measures should be attempted before the question is finally determined. Indeed, the diagnostic procedures and conservative measures recommended by the Consultants were implemented by Dr. Martens, all apparently to no avail.

Dr. Martens is claimant's treating physician, and his opinion concerning the propriety of a particular treatment modality is entitled to considerable weight. Earl Freeman, 34 Van Natta 1284 (1982), aff'd without opinion, 63 Or App 529 (1983); Lucine Schaffer, 33 Van Natta 511 (1981) ("On questions of the need for medical treatment, the Board will always defer to the treating doctor absent some compelling reason not to do so.") There is "some compelling reason" not to defer to Dr. Martens' recommendations in this case, when one considers the relatively uncertain benefit to be gained from surgery, weighed against the very predictable, undesirable effect that surgery will produce -- an ankylosed ankle joint.

In our mind, the most appropriate disposition of this case is to remand to the Referee for reconsideration in light of the additional medical opinion submitted by claimant in support of his request for remand, as well as other evidence bearing on the issue of the reasonableness and necessity of the proposed ankle fusion. We reach this conclusion for the following reason.

SAIF's denial is not premised on the theory that the proposed surgery will never be a reasonable and necessary form of medical treatment. The Referee's order, and our possible Order on Review affirming, would not have the effect of forever barring claimant from obtaining this form of treatment. See generally Patricia M. Dees, 35 Van Natta 120, 124 (1983). This record establishes that, although the proposed fusion may not now be reasonable and necessary, it is entirely possible that if claimant's pain syndrome continues unabated, and further conservative measures fail, the tide of medical opinion may turn in favor of the

reasonableness and necessity of this ankle fusion. As of the date of this order, more than a year has passed since the parties were before the Referee. In the interim, claimant has been examined and evaluated by another physician, Dr. Neumann, who has considered various treatment possibilities, including pain center treatment and ankle fusion for relief of claimant's pain. Like Dr. Martens, this physician is favorably inclined toward surgical fusion.

It may be appropriate on remand for the Referee to obtain a current evaluation by the Orthopaedic Consultants, see OAR 438-07-005(7), for consideration in light of circumstances that may have developed in the interim relative to any ongoing efforts to effectively alleviate claimant's pain syndrome by conservative forms of treatment. This is not to be construed as an order directing that any such evidence be marshalled; it is merely suggested as a possibility for developing a more satisfactory record on the difficult issue of the reasonableness and necessity of this proposed surgery.

ORDER

The Referee's order dated June 29, 1983 is affirmed in part, vacated in part, and remanded. That portion of the order which upheld the SAIF Corporation's denial of the proposed surgery for ankle fusion is vacated and remanded for further evidence taking and reconsideration in accordance with this order. The remainder of the Referee's order is affirmed.

DELPHIA D. SHORE, Claimant
Burt, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-06357 & 83-02286
September 21, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of that portion of Referee Seifert's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, SAIF contends claimant's underlying condition was not worsened as a result of her exposure while working for SAIF's insured and, therefore, Argonaut Insurance Company, the insurer for claimant's former employer, remains responsible on an aggravation theory. We agree and reverse.

Claimant is a 53 year old janitor. In January 1980 she filed a claim for bilateral carpal tunnel syndrome with Argonaut's insured. At that time, she had worked for Argonaut's insured for approximately 2 1/2 years. Argonaut accepted the claim. Following decompression surgery of both wrists, she was released for work in August 1980.

Claimant resumed working in December 1980 when she secured employment with SAIF's insured as a janitor. Her duties were similar to those performed during her previous employment. Claimant sought no medical attention from September 1980 until April 1981.

Claimant testified that the surgeries did not completely relieve her wrist pain and tingling. September 1980 chart notes

from her surgeon, Dr. Ellison, support claimant's testimony that her symptoms continued after the surgery. She further testified that her hands weakened during her employment with SAIF's insured and that her condition gradually worsened.

Three examining physicians have offered their opinions concerning responsibility for claimant's condition. Dr. Ferguson, claimant's family doctor, opined that it was difficult to decide which work exposure caused the most significant injury, but either or both contributed substantially. Dr. Bourdette, neurologist, was of the opinion that claimant's subsequent employment could have caused or materially worsened her symptoms since she was performing work similar to that which she was performing at the time of her initial onset of symptoms. Dr. Rosenbaum, neurologist, opined that the majority of claimant's symptoms were the result of her original injury and subsequent surgery, but that her latter employment must have played a part in accentuating her symptoms.

For SAIF, as insurer for the more recent employer, to be responsible under the last injurious exposure rule, the evidence must establish that claimant's exposure during her employment contributed to the course of, aggravated, or exacerbated the underlying disease. Boise Cascade v. Starbuck, 296 Or 238, 243 (1984); Bracke v. Baza'r, 293 Or 239, 250 (1982). We are persuaded that the most that can be said is that claimant's symptoms, rather than her underlying condition, were worsened during her employment for SAIF's insured. Under these circumstances the last injurious exposure rule does not apply. SAIF v. Baer, 60 Or App 133 (1982); Bracke v. Baza'r, supra. Consequently, Argonaut remains responsible for claimant's condition.

ORDER

The Referee's order dated December 19, 1983 is reversed. Argonaut Insurance Company's denial dated March 2, 1983 is set aside and the claim is remanded to Argonaut for payment of compensation as required by law. The SAIF Corporation's denial is reinstated and affirmed. Argonaut shall reimburse SAIF for all claim costs to date.

WILLIAM VAANDERING, Claimant
Brink, et al., Claimant's Attorneys
Schwenn, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-07420, 82-09180, 82-09204 & 82-10649
September 21, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of that portion of Referee Gemmell's order which set aside its denial of claimant's occupational disease claim for tinnitus. Western Employers (Western) cross-requests review of that portion of the order which set aside its denial of claimant's occupational disease claim for hearing loss. On review, the issues are timeliness and responsibility.

The Board finds the claim was timely filed against SAIF.

Even if the claim had not been timely filed, SAIF has not demonstrated any prejudice. ORS 656.807(5); ORS 656.265(4)(a).

The Board affirms that portion of the Referee's order which found Western responsible for claimant's hearing loss with the following comment. Although we agree Western is the responsible party, we believe the most logical "triggering event" for determining the date of disability is the date claimant first sought medical treatment. Under this analysis, as discussed below, Western remains the responsible insurer.

We reverse that portion of the order which found SAIF responsible for claimant's tinnitus condition. We find Western to be the responsible insurer for this condition also.

For approximately the last 10 years claimant, 54 years old at hearing, has worked as a heavy equipment operator. He has been employed by various employers, any number of which could have been responsible for claimant's hearing loss and tinnitus. The evidence preponderates that the onset of claimant's symptoms for both conditions occurred in 1979, while he was working for Progress Quarries, Western's insured. Claimant first sought medical treatment in January 1982, while unemployed. His most recent employer previous to seeking medical treatment was Coast Marine. Claimant has never lost time from work as a result of his conditions. His last employer was Todd Building Co., SAIF's insured. He worked for Todd from approximately June to July 1982.

Claimant testified his tinnitus worsened while he was working for Todd. Dr. Johnson, Phd., audiologist, testified that lower levels of noise can cause a worsening of tinnitus rather than a hearing loss. Dr. Johnson admitted there is no objective test available to determine a worsening of tinnitus. One must rely on subjective testing. Dr. Johnson found claimant "very reliable" in his responses to testing. In answer to separate questions, Dr. Johnson testified that claimant's tinnitus had significantly worsened, and had not worsened in any way.

Claimant worked for Todd for approximately one month. He wore ear protection throughout this time. Decibel readings taken at the Todd job site indicated that the noise levels were within acceptable non-injurious ranges. Audiograms taken in May 1982 and subsequent to the Todd employment did not indicate a worsening in claimant's hearing. No medical opinion indicates that claimant was disabled from working. Furthermore, claimant testified that he stopped working for Todd because he was laid off due to a lack of work. There is no explanation why claimant has not returned to work.

The Referee assigned responsibility for claimant's tinnitus to SAIF. The Referee found that claimant's condition worsened as a result of his employment at Todd and that he became disabled following his employment at Todd.

We are not persuaded that claimant's tinnitus worsened as a result of his employment at Todd. In the absence of objective testing, we are not convinced that the worsening was anything more than the natural progression of his underlying tinnitus condition. Further, we are unable to find convincing evidence that claimant was disabled from work at this, or any, time.

Where disability never results in time loss, but medical treatment is sought, the most logical "triggering event" for the date of disability is the date the claimant first sought that medical treatment. SAIF v. Carey, 63 Or App 68 (1983); Adam J. Gabel, 36 Van Natta 263 (1984).

Although claimant first became aware of both his hearing loss and tinnitus symptoms while working for Progress Quarries, he first sought medical treatment while he was unemployed. His most recent employer preceding his first medical treatment was Coast Marine. Since claimant worked for this Oregon employer while living on a job site in the State of Washington, the Referee found, and we agree, that claimant was not subject to Oregon Workers' Compensation Law during this employment. See Langston v. K-Mart, 561 Or App 709 (1982). Consequently, Progress Quarries, Western's insured, the next "potentially causal employer at the time disability occurs, is assigned liability for the cumulative whole." Bracke v. Baza'r, 293 Or 239, 248 (1982).

ORDER

The Referee's order dated October 26, 1983 is affirmed in part and reversed in part. That portion which set aside the SAIF Corporation's denial of claimant's occupational disease claim as it relates to tinnitus is reversed. SAIF's denial dated August 27, 1982 is reinstated and affirmed. Western Employers' denial of claimant's occupational disease claim as it relates to tinnitus is set aside and remanded to Western Employers for acceptance and the payment of compensation as provided by law. The remainder of the Referee's order is affirmed.

WALTER R. COWDREY, Claimant
Cash Perrine, Claimant's Attorney
Brian Pocock, Defense Attorney
Minturn, et al., Defense Attorney

WCB 82-08220 & 82-05938
September 24, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

United Pacific Company requests review of Referee Howell's order which set aside its denial of claimant's new occupational disease claim for his shoulder condition and upheld the SAIF Corporation's denial of claimant's alternative aggravation claim. We understand the only viable issue at this stage to be employer/insurer responsibility.

By stipulation approved August 7, 1981, claimant was awarded 25% scheduled disability to his left arm (shoulder) in connection with his employment at Lake County Forest Products, SAIF's insured. In May 1981 he began working with ZX Ranch, United Pacific's insured. Through late summer 1981 claimant's duties included driving trucks and tractors, occasionally lifting hay bales weighing about 150 pounds each and building and repairing fences. The fence building required digging fence post holes by hand. From about October 1981 until March 1982 claimant fed livestock. This activity required claimant to lift bales made heavier by snow and ice. On April 28, 1982 claimant's doctor requested that the SAIF claim be reopened. SAIF denied reopening. Claimant filed a claim with ZX Ranch on May 1, 1982, noting back, hip and shoulder problems. United Pacific denied the claim with regard to claimant's shoulders.

The last injurious exposure rule is applicable here. The Oregon Supreme Court, in Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984), explained:

> "Once a worker proves that the disability is work-related, he or she need not prove that any one employment caused the disability. The rule accomplishes that and makes liable the last employer whose conditions of employment might have caused the disability. . . .
>
> "In a procedural context, if a worker presents substantial evidence of successive work-related injuries causing disability, a prima facie case for recovery from the last employer is made out. Either or any employer against whom a claim is made still can present evidence to prove that the cause of the worker's disability is another employment or a cause unrelated to the employment. In such a case, the trier of fact decides the case on the basis of the evidence presented. If the trier of fact is convinced that the disability was caused by successive work-related injuries but is unconvinced that any one employment is the more likely cause of the disability, the finding is for the worker and against the last employer whose employment may have caused the disability."

In Bill B. Dameron, 36 Van Natta 592, 597 (1984), we discussed the application of Starbuck where, as here, there is no identifiable injury during the most recent employment. We said:

> "Once it is determined that the condition is otherwise compensable . . . , the primary inquiry is the causal relationship between the work activity performed for the various employers involved and the condition giving rise to the claim for compensation. The fact that there may be no incident or episode during the most recent employment which can be identified as an 'injury' is of less significance than the presence or absence of evidence establishing a materially causal connection between claimant's most recent work activity and the current claim for compensation. We understand Starbuck to require evidence of an actual, material contribution to claimant's disabling condition in cases which fall into the same factual category, in order to relieve an employer potentially responsible for payment of compensation pursuant to ORS 656.273 and 'shift' liability for payment of the claim to a more recent employer or insurer."

We have no doubt but that claimant's shoulder condition is work related. We find substantial evidence that, while working at ZX Ranch, claimant was repeatedly exposed to conditions capable of aggravating or exacerbating his underlying shoulder condition. Moreover, Orthopaedic Consultants' June 3, 1982 report and Dr. Rinehart's letters of June 28, 1982 and December 10, 1982 provide clear evidence that claimant's work at ZX Ranch actually and materially contributed to his disabling condition. Accordingly, we affirm.

ORDER

The Referee's order dated December 27, 1983 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by United Pacific Insurance Company. Said attorney's fee is to be in addition to claimant's compensation.

MARJORIE HEARN, Claimant
McNutt, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 83-03607
September 24, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Seifert's order which set aside its denial of claimant's occupational disease claim for a hand/forearm condition that has not been specifically diagnosed. SAIF contends that the medical evidence presented is insufficient to prove that claimant's work activities were the major cause of her hand/forearm pain and numbness. We agree with SAIF and thus reverse.

Claimant has worked for this employer as a fish packer and crab shaker off and on since 1980. She had symptoms of pain and swelling in both hands on prior jobs, but these symptoms had not been persistent. In December 1982 she returned to work shaking crabs. This activity required her to strike the cracked crab shells against the side of a pan in order to shake out the crabmeat. On or about January 17, 1983 claimant's right hand and arm became swollen. On January 25, 1983 claimant was examined by Dr. Lindsay, a general practitioner, who noted her complaints of numbness along the ulnar nerve distribution of the right forearm. The doctor found no swelling or redness and only minimal tenderness on the ulnar side of the right wrist. Dr. Lindsay diagnosed a right wrist sprain with possible ulnar nerve palsy.

Dr. Lindsay treated claimant by splinting her right wrist and taking her off work. A week later claimant's numbness along the ulnar distribution of her right forearm was improved in the sense that it was no longer constant. She had virtually no pain but did complain of considerable weakness in her arm and hand. Dr. Lindsay referred claimant to Dr. Smith, an orthopedist, for evaluation.

Dr. Smith's examination of February 8, 1983 revealed only mild tenderness along the volar aspect of the wrist with very slightly less strength in the right hand as compared to the left. Dr. Smith diagnosed a painful right forearm and wrist of undetermined etiology; he recommended that nerve conduction studies be performed to test for the possibility of either a

median or ulnar neuropathy. Those studies were later performed and were normal.

Dr. Smith reported to the insurer on February 28, 1983 that, since he could not identify any abnormalities in claimant's forearm or hand to account for her symptoms, he could not comment on the role which her employment might have played in the cause of her condition. The only known relationship of her symptoms to her employment was from her reported history.

On March 23, 1983 claimant was examined by Dr. Mann, an associate of Dr. Smith's. Dr. Mann's examination revealed only some redness over the dorsal aspect of the mid-right forearm and a mildly accentuated Tinel sign in the right elbow, as compared to the left, radiating to the small and ring fingers. Dr. Mann's impression was of right arm pain and numbness of unclear etiology which seemed to indicate a nerve compression problem, but that theory was not borne out by the nerve conduction tests. Dr. Mann decided to treat claimant with anti-inflammatory medication for three weeks.

By April 1, 1983 claimant returned to Dr. Mann complaining of pain in her left arm similar to what she had been experiencing for several months in her right arm. However, we only understand this claim and this proceeding to involve claimant's right arm problems.

Drs. Smith, Mann and Lindsay have expressed opinions. Responding to a question about the relationship between claimant's work and her right forearm condition, Dr. Smith opined:

> "I do not know. History is consistent with an industrial injury, but physical examination did not support this and all tests have been normal."

Responding to the same question, Dr. Mann stated:

> "Neither Dr. Smith nor I were able to identify the source of [claimant's] problem. I find no reason to doubt [claimant's] version of the development of her problem. Therefore, on that basis and that basis alone, I would have to say that there is a correlation between her symptoms and her work as a crab shaker."

Responding to an interrogatory from claimant's attorney, Dr. Lindsay "checked the box" which reads: "Yes, the right arm and hand medical symptoms which bother claimant were as a result of her employ at Eureka Fisheries, Inc."

Although the record is not entirely clear, it appears that claimant worked for this employer shaking crabs for a total of four days prior to filing her claim. She worked December 10, 11, 27 and 30. There was a layoff in early January 1983 and claimant was not working at the time she first sought medical treatment about the middle of that month. Claimant testified she was off work for approximately one month after filing her claim, and that she then went to work performing a lighter job as fish packer. She performed this fish packing job for approximately two months. Her employment history after that time is not in evidence.

Claimant continued to have problems in both her arms by the time of hearing in March 1984, with complaints of pain and swelling with strenuous activity; however, to repeat, we understand this proceeding to only involve the compensability of claimant's right arm problems.

We find that the above medical and circumstantial evidence is inadequate to prove that claimant's limited work activity with this employer was the major cause of her unknown right forearm condition. We think the thrust of Dr. Smith's opinion is to the contrary. We think that Dr. Mann's assessment of "a correlation" is, at least in the context of this case, clearly something much less than major causation. Dr. Lindsay's conclusory contribution, offered without supporting reasons or analysis in a case that literally cries out for supporting reasons and analysis, is not helpful. Assuming for the sake of discussion that Dr. Lindsay's opinion should be interpreted as an expression of major work causation, we are unable to find his opinion more persuasive than that of the two specialists, Drs. Smith and Mann.

ORDER

The Referee's order dated March 23, 1984 is reversed. The SAIF Corporation's denial dated April 12, 1983 is reinstated and affirmed.

DANNY D. KISHPAUGH, Claimant
Leo Probst, Claimant's Attorney
Roberts, et al., Defense Attorneys
Moscato & Byerly, Defense Attorneys

WCB 82-08701 & 82-08700
September 24, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Pferdner's order which set aside Diversified Risk Management Services' (DRMS) denial of responsibility for claimant's current low back condition, upheld Zurich Insurance's (Zurich) denial of responsibility for claimant's current low back condition and upheld a Determination Order's award of 48° for 15% unscheduled disability to claimant's low back. Responsibility and extent of disability are the issues on review.

Claimant strained his low back on March 17, 1980 while lifting a carton of candy which weighed about ten pounds. DRMS was the insurer on the risk. The claim was accepted and was closed with no award for permanent disability. Claimant missed work due to his back problems during the latter part of 1980. He was treated on a regular basis by a chiropractor from the time of his 1980 injury until June 1982. He was also treated by Dr. Miller. In November 1981 Dr. Miller opined that claimant should not do any work other than drive a forklift because of his "recurrent low back injuries."

On June 9, 1982 claimant was lifting a case of orange juice when he felt a snapping in his low back. Zurich was then the insurer on the risk. He was diagnosed as having a low back strain. The medical report states that his pain was "nonradiating". However, by June 17, 1982 a medical report from Dr. Gambee states that claimant had radiating left leg pain.

The record indicates that claimant had low back problems in the early 1970's. At that time he had some radiating leg pains. However, claimant testified that the radiating pains stopped and he had no further radiating leg pains until after the June 1980 lifting incident. Claimant was examined by Dr. Schmidt at Dr. Gambee's request on July 15, 1982. Dr. Schmidt opined that claimant has a chronic ligamentous injury with possible nerve root irritation causing the leg pains. Dr. Herbert, claimant's chiropractor, opined that the June 1982 incident worsened or aggravated claimant's condition. In deposition, Dr. Herbert testified: "Yes, this incident did worsen and it did aggravate. But that doesn't mean to me that it's a new injury."

Both insurers denied responsibility for claimant's condition. On October 25, 1982 an order was issued pursuant to ORS 656.307 naming DRMS as the paying agent. A Determination Order dated June 29, 1983 granted claimant an award of 48° for 15% unscheduled disability.

The Referee concluded that the responsible insurer was DRMS because he found that claimant's low back problems were merely a recurrence of his March 1980 injury. We disagree. Although it is true that claimant had continuing symptoms from the time of his March 1980 injury, his symptoms changed shortly after the June 1982 lifting incident. The record reveals that after 1973 claimant had no radiating leg symptoms until shortly after the lifting incident in June 1982. Furthermore, although his opinion is somewhat confusing, Dr. Herbert seems to state that the June 1982 incident actually contributed to claimant's disability. Actual contribution to the disability is sufficient to assign responsibility to the new injury insurer in responsibility cases such as this. Boise Cascade v. Starbuck, 296 Or 238 (1984). Accordingly, we find that claimant's incident of June 1982 constituted a new injury and that Zurich is the responsible insurer.

On the issue of extent of disability the Board affirms the Referee.

ORDER

The Referee's order dated October 5, 1983 is affirmed in part and reversed in part. That portion of the Referee's order setting aside DRMS's denial and upholding Zurich's denial is reversed. Zurich's denial is set aside and DRMS's denial is reinstated. That portion of the Referee's order concerning extent of disability is affirmed.

RODNEY R. LEECH, Claimant
Black, et al., Claimant's Attorneys
Robert Johnson, Attorney
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Carl Davis, Asst. Attorney General

WCB 82-08312
September 24, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The putative noncomplying employer requests review of Referee Gemmell's order which found that claimant was a subject employe of the employer. The employer raises several issues on review, but we reach only the question of whether claimant was not a subject

worker because his employment was casual under ORS 656.027(3).

Claimant's next-door neighbor, Ron Gafner, operates a business known as Gafner Building Design, which is the alleged noncomplying employer. In April 1982 Gafner contracted with Kenneth Gilbertson, the owner of a welding business, to construct an outbuilding for the welding business. Gilbertson acted as the general contractor on the project, arranging separately for concrete work, electrical work and carpentry to be performed by Gafner. As part of the contract, Gafner agreed to fabricate the four walls of the outbuilding and to raise them.

Ron Gafner and claimant had previously worked together as partners in the construction business. They had also worked together as employes of other businesses. At some point Ron Gafner and claimant had discussed the possibility of claimant doing extensive work on the Gilbertson project, but things did not work out that way. Instead, Ron Gafner only arranged to have claimant assist him on the day the four walls were to be raised. Although there is some dispute over the amount claimant was to be paid, we find that claimant would have been paid at least $100 per day worked.

The walls were scheduled to be raised on April 5, 1982. That morning, at about 10:30, one wall had been framed and was ready to be raised. Ron Gafner, claimant, Gilbertson and one other man unsuccessfully attempted to raise the wall using a forklift. Claimant was injured.

ORS 656.027 provides that all workers are subject to the workers compensation law enumerated in that statute. ORS 656.027(3) states that one of the exceptions is: "A worker whose employment is casual." ORS 656.027(3) defines "casual" as "employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200." Claimant was Gafner's only employe, so Gafner's "total labor cost" is necessarily limited to the amount that claimant would have been paid.

Claimant was hired just to frame and raise the four walls. He testified that, in his opinion, it would have taken two days to complete that task. Ron Gafner testified that, in his opinion, all four walls would have been raised in one day. The Referee's order seems to suggest that she resolved this conflict on credibility grounds, accepting claimant's opinion because she found claimant credible.

If that was the Referee's intended analysis, we do not agree that the question of how long it would have taken to raise the walls is a question of historical fact on which credibility is determinative. Rather, we think it is a question of the relative persuasiveness of different opinions or judgments. Stated bluntly, the issue is not who is telling the truth; the issue is which estimate of the length of time a given construction activity would take is more likely correct.

The circumstantial evidence supports Ron Gafner's estimate. One wall was ready to be raised by 10:30 a.m. on a regular work day, which suggests to us that all four walls could have been finished in one work day. However, we need not make that finding. We understand that it is claimant's burden to prove that

he does not come within the casual labor exception, i.e., to prove that Ron Gafner's payroll would have been more than $200, i.e., to prove (in light of our prior findings) that the specific construction task claimant was hired to participate in would have taken two full days. The only evidence concerning the length of time needed to complete the work is the conflicting estimates of claimant and Ron Gafner. In order for claimant to sustain his burden, we would have to affirmatively say that we find his estimate more likely correct. We are unable to find any comfortable basis in the record for picking one party's opinion over the other on this ultimate issue, other than the limited circumstantial evidence noted above, which is adverse to claimant's position.

ORDER

The Referee's order dated October 11, 1983 is reversed. The Proposed and Final Order issued on July 29, 1982 is reversed. The acceptance of claimant's claim by the SAIF Corporation, as processing agent for the putative noncomplying employer, is reversed.

MARCIE J. MERRITT, Claimant
Garry L. Kahn, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06869
September 24, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Fink's order which set aside its denial of claimant's industrial injury claim and which ordered it to pay certain medical expenses.

The Board affirms those portions of the Referee's order concerning the compensability of the claim.

On the issue of the contested medical expenses, we find that these expenses are litigation expenses rather than reasonable and necessary medical treatment which would be compensable under ORS 656.245. Litigation expenses are not compensable. Joean Cisco, 34 Van Natta 1030 (1982).

ORDER

The Referee's order dated January 26, 1984 is affirmed in part and reversed in part. That portion of the Referee's order requiring the SAIF Corporation to pay certain medical expenses is reversed. The balance of the Referee's order is affirmed. Claimant's attorney is awarded $450 for services on Board review, to be paid by the SAIF Corporation.

STEPHEN B. COX, Claimant
Francesconi & Cash, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 83-12229
September 25, 1984
Order Denying Motion to Dismiss

Claimant has moved to dismiss the insurer's Request for Board Review on the ground that it was untimely filed.

The Referee's order was issued July 12, 1984. The 30th day after July 12, 1984 is August 11, 1984, a Saturday. The insurer's Request for Board Review was mailed on Monday, August 13, 1984.

In computing time periods, if the last day falls on a Saturday, Sunday or legal holiday, the period runs until the end of the next business day. OAR 438-05-040(4)(c). Consequently, the insurer's request was timely filed.

Accordingly, claimant's motion to dismiss is denied.

IT IS SO ORDERED.

WILLIAM MARSHALL, Claimant
Evohl Malagon, Claimant's Attorney
Roberts, et al., Defense Attorneys
Velure & Bruce, Defense Attorneys

WCB 83-01395 & 82-10740
September 25, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

Mission Insurance Company requests review of that portion of Referee Seymour's order which set aside its denial of claimant's lateral epicondylitis condition. On review, Mission contends claimant's lateral epicondylitis condition is not compensable and, if the condition is compensable, EBI Companies is the responsible party. We agree that the elbow condition is not compensable and reverse.

Claimant is a 32 year old metal worker. On April 15, 1982, while working for Mission's insured, claimant was guiding a steel plate when one side of the plate slipped. The force of the slip combined with claimant's pushing action caused claimant's body to twist. Claimant testified he experienced pain in his lower back and in the outer part of his elbows. A co-worker testified that claimant only mentioned hurting his back, not his elbows. Claimant's supervisor was aware of the incident.

Believing he had sustained a "muscle-type strain", claimant did not seek medical attention. Claimant continued to work until April 20, 1982, at which time Mission's insured went out of business.

Although claimant started to investigate how to initiate a claim in June, he did not file his claim against Mission's insured until September 1, 1982. Due to the closure of the business, claimant found it difficult to obtain the proper forms. From his experiences as foreman, claimant was familiar with workers' compensation procedures and was aware that Mission was the employer's carrier. However, he felt that his former superiors were the appropriate officials to handle the matter.

Claimant was unemployed until late August, when he obtained a metal worker position with EBI's insured. Claimant described himself as "constantly busy" during this hiatus. He continued work on a barn at his 5 acre farm. The barn's construction had begun in January, with the majority of the work occurring in March. Claimant also constructed a small woodshed (12' x 20'), insulated his garage, worked around his yard and stored hay.

Although claimant felt elbow pain at the time of the April 1982 injury, he did not experience numbness and tingling in his hands until approximately 2 or 3 weeks after he had left the job. Claimant noticed that his symptoms worsened when he hammered nails while performing some stallwork for his barn.

While employed for EBI's insured, claimant's work activities were more physical than his foreman position at Mission's insured. His duties required extensive and repetitive hand movements, such as hammering. Claimant felt these activities worsened his condition.

Claimant first sought treatment on September 3, 1982. He was examined by Dr. Raether, who became his treating physician. Dr. Raether noted that claimant sustained an "ill-defined back injury on April 15, 1982," and shortly thereafter experienced numbness in his hands and pain along the lateral aspect of both elbows.

By letter dated October 11, 1982 Dr. Raether described claimant's primary problem as lateral epicondylitis, an inflammation involving the attachment of the forearm muscles about the lateral aspect of the elbow. Dr. Raether noted that this condition could be caused by repetitive use of the forearm and wrist, particularly where a gripping motion was involved. Since claimant's present work with EBI's insured involved considerable pounding, there seemed to be "little question" in Dr. Raether's mind that the injury was work related. It was also significant to Dr. Raether that claimant had no elbow problems while he was unemployed. As noted above, claimant testified that his elbow problems persisted during his summer of unemployment.

Dr. Englander performed a neurological examination on October 27, 1982. Dr. Englander opined that the lateral epicondylitis was not the result of work activities of April 15, 1982. The doctor based his opinion on claimant's ability to function without seeking medical attention until after beginning a different job, some 4 and 1/2 months after the incident. Additionally, the doctor felt that claimant's April job was unlike the type of repetitive activity that is usually associated with the condition. If there was a work related pathology, Dr. Englander felt that EBI's insured was responsible. However, Dr. Englander reported that it was at least as probable medically that non-employment activities were the major contributing factor to claimant's problems.

By letter dated November 5, 1982 Dr. Raether opined that it was "indeed medically probable" that claimant's work activity at Mission's insured and the April incident were not the primary contributing factors in claimant's current elbow problems. Dr. Raether felt that claimant's condition was an occupational disease for which EBI's insured had "indeed made an independent contribution."

Mission issued its denial on November 11, 1982. Soon after, claimant filed a claim against EBI, who also issued a denial.

Claimant was examined by Dr. Puziss, orthopedist, on July 26, 1983. Dr. Puziss opined that, assuming claimant's history was credible, it appeared that his elbow problem began with an April 15, 1982 injury. However, the doctor questioned the seriousness of claimant's symptoms stemming from the incident because claimant had not sought medical treatment. Furthermore, Dr. Puziss stated that a sudden stretch injury as described by claimant is "highly unlikely to cause the kind of chronic forearm injury" that claimant is experiencing. Dr. Puziss suspected "very strongly" that claimant's forearm injuries were not the result of any work

related activity in April "whatsoever." Given claimant's summer activities and the filing of his claim within days of beginning work with EBI's insured, Dr. Puziss did not think claimant's activity at EBI's insured materially caused his symptoms.

The Referee found claimant entirely credible. Since Dr. Puziss's opinion was prefaced on the assumption that claimant was credible, the Referee found the doctor's opinion persuasive. Therefore, he found Mission responsible.

Claimant's "entirely credible" testimony certainly establishes a temporal relationship between claimant's work activities and his epicondylitis condition. However, we find the medical evidence concerning causation insufficient to prove either a major or material work contribution by either Mission's or EBI's insured.

The preponderance of the persuasive medical evidence establishes that it is unlikely claimant's condition was caused by an injury. The condition is generally associated with repetitive activity. It is true claimant engaged in physical repetitive activities while working for Mission's insured and, subsequently, EBI's insured. However, during the period of time in question claimant was also involved in a number of off-the-job activities, all of which incorporated physical repetitive activities of the type generally associated with the condition. Claimant testified that the majority of the work on his barn was performed in March 1982, prior to the April 1982 incident. Further, claimant did not seek medical treatment for his elbow condition until approximately 4 months after he stopped working for Mission's insured and 2 days after he began working for EBI's insured. This commencement of treatment followed a summer in which claimant described himself as "constantly busy" on his farm, engaging in activities such as working on barn stalls, erecting a wood shed, insulating his garage, doing yard work and storing hay. Finally, claimant admitted having symptoms after these off-the-job activities.

Neither are we persuaded that EBI is responsible for an occupational disease. Dr. Raether suggests that EBI is responsible. However, his opinion was based on the incorrect premise that claimant had been asymptomatic prior to his work with EBI's insured. Dr. Englander stated that if claimant's condition was work related, EBI was responsible. However, in the same report the doctor qualified the opinion, reporting that it was at least as probable medically that non-employment activities were the major contributing factor of claimant's elbow problems.

We are not persuaded that the April 1982 injury with Mission's insured caused the problem, and finding that the epicondylitis condition existed prior to working for EBI's insured, we are also not persuaded that claimant's work activities for EBI's insured were the major contributing cause of any worsening of his condition.

ORDER

That portion of the Referee's order dated January 17, 1984, which set aside Mission Insurance Co.'s denial of November 11, 1982, is reversed. Mission's denial, insofar as it pertains to claimant's lateral epicondylitis condition, is reinstated and affirmed.

CLAIR McCOMBER (Deceased), Claimant
Lewis Myatt, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Edward Stepnoski, Defense Attorney

WCB 83-06293 & 83-06294
September 25, 1984
Order Denying Motion to Dismiss

The self-insured employer has moved to dismiss the SAIF Corporation's request for Board review on the ground that it was untimely filed.

The Referee's order was issued August 10, 1984. The 30th day after August 10, 1984 is September 9, 1984, a Sunday. SAIF's request for Board review was filed on Monday, September 10, 1984.

In computing time periods, if the last day falls on a Saturday, Sunday or legal holiday, the period runs until the end of the next business day. OAR 438-05-040(4)(c). Consequently, SAIF's request was timely filed.

Accordingly, the employer's motion to dismiss is denied.

IT IS SO ORDERED

LETTIE REYNOLDS, Claimant
Bischoff & Strooband, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 82-02757
September 25, 1984
Order of Abatement

The Board has received the insurer's motion for reconsideration of our Order on Review dated August 31, 1984.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

ALFRED SOTTOSANTI, Claimant
Burt, et al., Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 83-05601
September 25, 1984
Order Denying Motion for Remand

Claimant moves for remand to supplement the record with medical evidence not obtainable at the time of hearing. The self-insured employer opposes claimant's motion.

The Board denies claimant's motion on the grounds that the evidence seems to be cummulative and does not significantly add to the evidence already contained in the record. On review, the Board has not and will not consider the proffered evidence except as necessary to rule on the remand motion.

IT IS SO ORDERED.

WALTER W. VOLKERS, Claimant
Olson Law Firm, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 83-05701
September 25, 1984
Order Denying Attorney Fees

Claimant has petitioned the Board for an award of attorney's fees in connection with our Order of Dismissal dated August 23, 1984.

Claimant prevailed at hearing and the self-insured employer

requested review. Subsequently, the self-insured employer withdrew its request for review. Accordingly, the Board then issued its Order of Dismissal.

We find that claimant's attorney was not instrumental in defending the Referee's order because the self-insured employer voluntarily withdrew its request for review. We, therefore, deny claimant's motion.

IT IS SO ORDERED.

SUZANN E. WILLIAMS, Claimant
Brink, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-04201
September 25, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Pferdner's order which upheld the insurer's denial of claimant's aggravation claim.

Claimant sustained a compensable low back injury in March 1980. Her claim was first closed by a May 1981 Determination Order which awarded her 20% unscheduled disability. Her claim was later reopened due to an aggravation and reclosed by a December 1981 Determination Order which granted no additional compensation for permanent disability.

Claimant's request for hearing on the December 1981 Determination Order was the subject of a prior proceeding which led to a hearing before Referee Menashe on November 16, 1982. Referee Menashe issued an order on December 14, 1982 which granted claimant an additional 10% unscheduled disability.

Claimant again requested reopening due to an aggravation, which the insurer denied. Claimant again requested a hearing, which led to this proceeding.

In this case, Referee Pferdner concluded that claimant had failed to prove that her condition had worsened since the last arrangement of compensation. Referee Pferdner stated that the last award of compensation was on December 14, 1982, which was the date of Referee Menashe's order in the prior proceeding. That is incorrect. Actually, for the reasons stated in Joseph R. Klinsky, 35 Van Natta 332, aff'd without opinion 66 Or App 193 (1983), the date of the last award of compensation was November 16, 1982, the date of the hearing before Referee Menashe.

In June 1982, before the last award, claimant began seeing Dr. Berkeley, a neurologist. At that time he reported hypalgesia in the left L5 dermatome. Claimant's next recorded visit to Dr. Berkeley was on November 23, 1982, shortly after the hearing in the prior proceeding. Claimant was then complaining of increased pain. Dr. Berkeley stated: "Essentially her examination today, was not any different from the one in June, 1982 though the level of the pain as well as the distribution have increased since that last examination . . ."

Claimant visited Dr. Berkeley again on January 11, 1983. Dr. Berkeley reported that claimant's pain had worsened. He noted that a CT scan that had been performed the prior month had shown some degenerative changes which might be contributing to claimant's radiating pain. Dr. Berkeley performed a myelogram on

January 20 to rule out nerve root entrapment. Following the myelogram he opined:

> "[Claimant] appears to have bulging L4-5 disk, but particularly abnormalities in the lateral recess at L4-5 on the left side, with severe angulation of the root on that side, which is compatible with the patient's symptomatology."

On February 19, 1983 Dr. Berkeley reported to the insurer that he did not think claimant's present condition represented a worsening of the 30% disability she had previously been awarded. On March 14, 1983 Dr. Smith examined claimant at Dr. Berkeley's request. Dr. Smith opined that claimant had a nerve root lesion at L5 with facet impingement which probably caused her radiating left leg pain. He recommended weight reduction, a back brace and suggested that surgery might be indicated. On March 25, 1983 Dr. Berkeley requested authorization from the insurer to perform surgery. The insurer issued a denial on March 30, 1983.

On June 15, 1983 Orthopaedic Consultants examined claimant at the insurer's request. The panel compared claimant's condition at that time with her condition at the time of a prior October 1981 examination:

> "The objective findings . . . have not appreciably changed. Subjectively, the patient feels that her condition has definitely worsened since January of this year. Objectively, there have been some aberrations noted, both in the CT scan and the myelogram. However, in spite of this, I feel that any surgical approach to this woman's problems should be a very last resort."

On August 19, 1983 Dr. Berkeley saw claimant and noted that her condition was worsening. Claimant entered the Northwest Pain Center for evaluation on August 24, 1983. Dr. Seres of the Pain Center opined that claimant had mechanical back problems with no evidence of "a significant nerve root problem."

On November 14, 1983 Dr. Berkeley wrote to claimant's attorney:

> "It is my opinion that [claimant] was unable to work as a result of the aggravation of her condition and increased symptoms of low backache as well as the spreading of her buttock and hip pain, not only to the left, but now to the right side as well since March 24, 1983, when I saw the patient in my office. The patient has been unable to return to any type of gainful employment and it is true that by the time I saw her on August 19, 1983, even simple house chores could not be performed by the patient without significant pain forcing her to stop and lie down."

* * *

"The fact remains however, that 1) this lady continues to be symptomatic and is unable to work, 2) her condition got worse since January 1983, and 3) she has a positive lumbar myelogram and CT scan, both of which suggest a degree of lateral recess syndrome with canal stenosis . . ."

Although we find some portions of Dr. Berkeley's reports to be confusing, we conclude that the overall tenor of his reports supports a finding that claimant's condition worsened at some point after November 1982.

The more difficult question is when claimant's condition worsened. The CT scan on December 10, 1982 provides some indication that claimant's condition had worsened since Dr. Berkeley first saw claimant in June 1982. On the other hand, as late as February 1983 Dr. Berkeley reported to the insurer that claimant's condition did not represent a worsening of the 30% disability she had previously been awarded. Apparently that statement was intended to mean that Dr. Berkeley did not believe claimant had any greater permanent impairment than previously. But a compensable condition can become aggravated pursuant to ORS 656.273 without any increase in permanent impairment or disability.

The myelogram performed on January 20, 1983 provides objective evidence that claimant's condition had worsened. It is also an important basis for Dr. Berkeley's opinion that claimant is in need of surgery. At one point Dr. Berkeley stated that time loss should be authorized from the date of the myelogram. Dr. Berkeley later confused the issue by stating that claimant was unable to work after March 23, 1983.

We conclude that claimant is entitled to time loss benefits beginning January 20, 1983. It was on that date that there was sufficient objective evidence to confirm a worsening and that is the first date Dr. Berkeley assigned for claimant's inability to work.

ORDER

The Referee's order dated December 12, 1983 is reversed. The insurer's denial dated March 30, 1983 is set aside and claimant's aggravation claim is remanded to the insurer for acceptance, processing and payment of benefits as required by law, including benefits for temporary disability beginning January 20, 1983. Claimant's attorney is awarded $1000 for services rendered at hearing and $550 for services rendered on Board review, to be paid by the insurer.

GREG BECKER, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-08178
September 26, 1984
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated August 30, 1984.

The request is granted. On reconsideration, the Board adheres to its former order.

IT IS SO ORDERED.

Board Member Barnes Concurring:

Claimant's request for reconsideration rasies a legal issue about entitlement to attorney fees on Board review.

Claimant requested Board review and argued in his brief that the unscheduled disability award granted by the Referee should be increased. The insurer did not cross request review, but argued in its brief that the disability award granted by the Referee should be reduced. Claimant filed a reply brief with further argument on the issue of extent of disability. Our August 30, 1984 Order on Review affirmed the Referee.

Claimant's position now is that he should be awarded an insurer-paid attorney fee for, in effect, successfully defending the disability award granted by the Referee in the face of the insurer's argument that the Referee's award should be reduced. I believe that the Board's actions in this context have not been completely consistent, but I join in denying claimant an attorney fee based on my understanding of what the Board usually does in this kind of situation.

(1) We permit a respondent that did not cross-request review to raise issues and claims for relief in its brief that are in addition to or different than the issues/claims that were raised in the brief of the party that requested review. E.g. Jimmie Parkerson, 35 Van Natta 1247 (1983).

(2) If an employer/insurer, appearing as respondent, raises an additional issue in its brief, claimant's attorney files a reply brief responding to that additional issue, and the Board affirms the Referee on that additional issue, then we award claimant's attorney an insurer-paid fee for services rendered in filing the reply brief. E.g. Judy M. Freidrich, 36 Van Natta 1210 (1984); see also Teel v. Weyerhaeuser Co., 294 Or 588 (1983).

(3) The present situation does not come within point two, above, because that doctrine only applies when an additional and different issue is raised in the respondent's brief, and we have previously determined that extent of disability is a single issue, i.e., responding to the argument that an award should be increased with the contention that the award should be decreased does not raise an additional or different issue. See Gleason W. Rippey, 36 Van Natta 778 (1984).

Since most of the results that are probably inconsistent with the above statements have been in unpublished orders, I add these comments in the hope that a published explanation of our action in this case might make it more likely that the Board will do something along the same lines in the next similiar case.

BETTY BERGSTROM, Claimant
Virgil Osborn, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-10941
September 26, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Mongrain's order which upheld a Determination Order awarding no unscheduled disability benefits for injury to claimant's low back.

The Board affirms and adopts the order of the Referee. The evidence shows that claimant had marked degenerative changes in her lumbar spine before she sustained her compensable injury diagnosed as an acute lumbar strain, which occurred when claimant fell from a chair upon which she was standing. The medical evidence does show that claimant's lumbosacral strain had resolved without residuals.

ORDER

The Referee's order dated January 20, 1984 is affirmed.

DANNY E. CRABB, Claimant
Rodriguez, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-11481
September 26, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Seifert's order which upheld the SAIF Corporation's denial of current medical treatment for his right knee and associated time loss.

Claimant suffered a compensable injury to his right knee, right wrist and chest on June 27, 1983. He felt a snap in his right knee when forcibly applying the brakes of the car he was driving. When examined by Dr. Waldmann that day, claimant complained of pain in the right knee, right wrist and chest. Dr. Waldmann observed that the knee was diffusely tender, without effusion. He also observed that the McMurray test for meniscal tearing was positive. Claimant's knee and chest x-rays were normal. Dr. Waldmann diagnosed knee contusions and strain. He referred claimant to Dr. Mahoney, an orthopedist.

On July 8, 1983 claimant saw Dr. Mahoney. Claimant related that he had undergone a medial meniscectomy approximately two and one-half years before. Claimant had never recovered from the surgery and continued to experience pain along the retropatellar area of the knee associated with popping, catching and clicking, as well as medial jointline pain. In addition, a feeling of instability of the knee had continued.

Claimant told Dr. Mahoney that the work injury resulted when he forcibly applied the brakes with his right foot. The doctor noted that there may have been some twisting to the foot. Claimant reported that since the injury his symptoms had worsened, he had experienced more pain, popping and catching in the knee and a more generalized feeling of insecurity about the knee. Dr. Mahoney's impressions regarding the knee included the possibility of a retear of the medial meniscus or aggravation of medial compartment osteoarthritis since the accident. Claimant was continued on an anti-inflammatory agent and released for work.

Claimant saw Dr. Mahoney again on July 25, 1983. The doctor noted that claimant's symptoms were somewhat relieved by the anti-inflammatory agent, but that claimant had twisted his knee playing softball and experienced a sudden increase in pain.

Dr. Mahoney summarized his overall impressions regarding causation and the need for further treatment in his December 23, 1983 letter. He stated:

> "As you are well aware, he was also injured at work on 6/26/83. He had increase in his symptoms. It is also known that he sustained another injury in July which was a twisting injury to the knee in softball. I do not know whether the on-the-job accident caused any 'new' injury to his knee purely. Obviously, he is having increasing symptoms. The injury may have just aggravated his osteoarthritis. There is a possibility he may have had an incomplete meniscectomy by Dr. Corrigan three years ago, causing his symptoms. He may also have retorn the medial meniscus at the time of the on-the-job auto accident. There is also the softball injury question. I really do not know how the softball injury question fits into this. From my point of view as a physician, I do not think the softball injury is of any significance. He was having increase in his symptoms severe enough to see me on July 8, 1983, prior to the softball injury. I doubt very much whether the softball injury has anything to do with his underlying problem. The underlying problem is osteoarthritis of the knee with or without a tear of the medial meniscus. The most reasonable treatment for this problem would be an arthroscopic examination of the knee with resection of a medial meniscal tear if this is found."

Claimant has the burden of proving that the condition for which he is to receive medical services was caused by his compensable injury and that the treatment is reasonable and necessary. See e.g. Poole v. SAIF, 69 Or App 527 (1984). Claimant clearly suffered a compensable injury to his right knee on June 27, 1983. The evidence preponderates in favor of finding that the said accident is a material cause of the symptoms for which he now seeks medical treatment and that the proposed arthroscopic examination with possible resection of medial meniscal tear is reasonable and necessary treatment therefor. Even if we did not so hold, the arthroscopic examination would clearly be necessary to determine whether claimant's condition is causally related to the compensable injury, and hence compensable. See Myrtle L. Thomas, 35 Van Natta 1093, 1095 (1983). Accordingly, we reverse the Referee's affirmation of SAIF's denial of medical services and order that the claim be accepted.

ORDER

The Referee's order dated April 25, 1984 is reversed. The claim for medical services is ordered accepted. Claimant's attorney is awarded $1,200 for services before the Referee at hearing and on Board review, to be paid by the SAIF Corporation.

RICHARD L. CROOK, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 83-08025
September 26, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of those portions of Referee Brown's order which: (1) upheld the SAIF Corporation's denial of an aggravation claim; (2) denied claimant additional interim compensation; (3) denied claimant penalties and attorney fees for an alleged failure to accept or deny claim within 60 days after the claim was filed; and (4) awarded claimant's attorney $250 for services rendered in obtaining reversal of SAIF's denial of current upper back treatment.

The Board modifies the order of the Referee insofar as it establishes $250 as a reasonable fee for services rendered by claimant's attorney in obtaining reversal of SAIF's denial of current upper back treatment. The Board affirms and adopts the order of the Referee in all other respects.

On January 19, 1981 claimant suffered a compensable injury to his dorsal spine. He was awarded 48° for 15% unscheduled permanent disability by an Opinion and Order dated April 18, 1983. The order described claimant's complaints as of the March 15, 1983 hearing as follows:

> "Claimant had occasional sharp pains between his shoulders, an aching pain in his shoulders and periodic leg numbness and heachache [sic]. His shoulders became tight and his back stiff from too much driving. He avoided 'throwing his kids around', playing baseball and hiking because of back pain."

On May 2, 1983 Dr. Robert M. Carlock, D.C., claimant's treating doctor, wrote SAIF that he continued to treat claimant on an as-needed basis for palliative purposes. He explained that claimant came to the office for treatment only on occasions when he could not tolerate the mid back pain any longer. Dr. Carlock stated that he was treating claimant once or twice monthly and that although treatment relieved the burning pain between claimant's shoulders at spinal level T4 through T7, the adjustments were not going to totally cure claimant's problem. Dr. Carlock stated that he suspected claimant would have occasional symptoms in that area for a very long time.

In his August 10, 1983 letter to SAIF, Dr. Carlock stated that claimant required an increase in the number of office visits during July 1983. He stated that claimant reported suffering from

severe headaches and mid dorsal pain, but that most recently his symptoms had begun to remit with additional treatments. Dr. Carlock's September 13, 1983 letter to SAIF further buttressed his position that the condition for which he was treating claimant stemmed directly from the original compensable injury.

Dr. James R. Degge, M.D., examined claimant at SAIF's request. In his September 23, 1983 report he stated:

> "Second, he has a congenital last lumbar vertebra, sacralized by the right transverse process, which is a source of postural low back symptoms and this condition is accounting for ongoing symptoms in the lumbar area. It is not a work-related condition. It was neither aggravated nor accelerated by the accident under consideration.
>
> "As far as the work-related injuries are concerned, his condition is stationary. Claim closure can be undertaken. Current chiropractic treatment is palliative only for non-work related conditions and would more properly be carried under his private insurance."

Subsequently, SAIF issued a denial letter on October 14, 1983 not only rejecting the aggravation claim, but also denying present treatment. SAIF explained: "Further, the need for your present treatment is a result of the congenital abnormality in your lower back and not needed as the result of your work- related condition."

The Referee found present treatment for claimant's upper back to be compensable, set aside that portion of SAIF's denial and awarded claimant's attorney $250 for services rendered "in clarifying the ambiguity."

We find no ambiguity in SAIF's blanket denial of present medical treatment. When the denial is read in conjunction with Dr. Degge's report, SAIF's position could not have been clearer.

ORS 656.386(1) requires the award of a reasonable attorney's fee when a claimant prevails at hearing on a denied claim. The amount to be deemed reasonable is to be determined based on the efforts of the attorney and the results obtained, subject to certain maximums. OAR 438-47-010(2). SAIF's blanket denial of current treatment necessitated the hearing before the Referee. Although claimant raised a number of issues at the hearing, a substantial part of claimant's attorney's efforts were related to the medical services issue. A substantial benefit was obtained for claimant, as his chronic back condition will likely require occasional treatment for quite some time.

Considering claimant's attorney's efforts and the results obtained, we find $750 to be a reasonble attorney's fee. Accordingly, we increase the Referee's award of attorney fees to claimant's attorney by $500.

ORDER

The Referee's order dated February 23, 1984 is affirmed in

part and modified in part. The Referee's order of $250 attorney's fees for services rendered in connection with the reversal of the SAIF Corporation's denial of current upper back treatment is modified and attorney's fees of $750 for said services are ordered in lieu thereof. The Referee's order is affirmed in all other respects.

ANGELINA GONZALEZ, Claimant
Gatti & Gatti, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-10708
September 26, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of that portion of Referee Quillinan's orders which: (1) awarded claimant 5% (7.5°) scheduled permanent disability for a left knee injury; (2) awarded claimant 15% (48°) unscheduled permanent disability for a low back injury and (3) awarded claimant 5% (16°) unscheduled permanent disability for a neck injury. An August 13, 1983 Determination Order had awarded claimant no scheduled or unscheduled permanent disability. Claimant cross-requests review contending: (1) SAIF failed to pay the correct temporary total disability rate; (2) SAIF failed to make these payments within 14 days of notice and (3) SAIF should be assessed penalties and attorney fees for its allegedly unreasonable conduct.

We find that claimant has failed to prove that she has incurred permanent disability and thus reverse all of the Referee's awards of permanent disability.

Claimant is a 29 year old cannery worker. In October 1982 she sustained a compensable injury when she slipped and fell on a wet floor. Claimant landed on her back, slid across the floor and struck her left knee on a pillar.

Claimant's condition has been generally diagnosed as cervical and lumbar strain. She also sustained a contusion of the left knee. X-rays have been negative. Treatment has been conservative.

In December 1982, following several months of chiropractic treatment, claimant was evaluated at the Callahan Center. Dr. Henry, psychologist, reported that claimant's evaluation reflected a "rather acute emotional distress related primarily to marital and family difficulties." These difficulties were not related to claimant's industrial injury in the psychologist's opinion. Dr. Henry further opined that claimant represented a "somewhat greater than average risk for falling into a role of chronic disability."

In January 1983 claimant was examined by Dr. Stevens, orthopedist. Dr. Stevens found nothing specific to indicate intra-articular injury of her left knee. The doctor diagnosed left knee contusion, with persistent mild patellar tendinitis. Dr. Stevens noted that the "amount of discomfort registered is somewhat more than one might expect."

In March 1983 Dr. Utter, claimant's then-treating chiropractor, declared claimant medically stationary as of February 2, 1983 and released her for regular work. Dr. Utter opined that claimant's left knee was excellent and that she had 10% permanent impairment relating to her cervical and lumbar spine.

By letter dated April 30, 1983 Dr. Murphy, of BBV Medical Services, also found claimant medically stationary. The doctor noted that claimant's complaints of neck, low back and left knee pain continued. However, Dr. Murphy found no objective evidence of impairment. It was Dr. Murphy's opinion that claimant did have cervical pain, which increased in the form of headaches when the neck's motion neared normal outer limits.

In August 1983 Dr. Utter reported that he did not concur with the "BBV" report and advised that he had referred claimant to Dr. Bolin, chiropractor.

Claimant was examined by Dr. Bolin, chiropractor, in September 1983. Dr. Bolin noted no left knee abnormality, other than tenderness at the medial collateral ligament and meniscus. Cervical range of motion was above average. X-rays indicated a subluxation of the cervical spine which the doctor believed to be chronic and unrelated. Dr. Bolin attributed claimant's low back pain to a facet syndrome due to claimant's obesity. Dr. Bolin recommended a neurological examination to rule out neuropathology of the upper cervical spine. It was Dr. Bolin's ultimate opinion that claimant had no measurable impairment.

In August 1983 claimant began treating with Dr. Berman, a chiropractor. In November 1983 Dr. Berman reported that claimant demonstrated an approximately 20% decrease in cervical and lumbar ranges of motion with pain and tenderness at the extremes of mobility. The doctor also noted muscle spasms in the cervical and lumbar areas. Dr. Berman opined that claimant displayed characteristics consistent with a permanent partial impairment involving the traumatized areas. Based on claimant's reported symptoms, Dr. Berman felt claimant suffered from a chronic cervical and lumbar strain/sprain and pain syndrome.

The Referee acknowledged the lack of objective evidence of permanent impairment. However, apparently based upon claimant's testimony, the Referee granted claimant awards of permanent knee, back and neck disability.

We find that claimant has failed to prove that she has sustained permanent impairment as a result of her compensable injury. We find no evidence of permanent left knee impairment attributable to claimant's compensable injury. Regarding back/neck impairment, we do not find the opinions of her former and present chiropractors convincing. Dr. Utter felt claimant had sustained 10% cervical and low back impairment; however, that opinion was based on an examination which occurred before claimant was declared medically stationary. Dr. Berman's opinion of cervical and low back permanent impairment is primarily based on claimant's symptomatology. Dr. Bolin acknowledged claimant's symptoms, but attributed them to nonwork factors. We find Dr. Bolin's opinion as plausible, if not more plausible, than Dr. Berman's.

We affirm and adopt those portions of the Referee's order concerning the time loss rate, the date time loss was due and claimant's request for penalties and attorney fees.

ORDER

The Referee's orders dated March 6, 1984 and March 16, 1984 are affirmed in part and reversed in part. Those portions of the Referee's orders which awarded claimant scheduled and unscheduled permanent disability are reversed, and, in lieu thereof, the Determination Order dated August 11, 1983, is reinstated and affirmed. The remainder of the Referee's order is affirmed.

DELBERT LAWSON, Claimant
Steven Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Brian Pocock, Defense Attorney
Miller, et al., Attorneys

WCB 82-10501 & 82-11235
September 26, 1984
Interim Order Remanding

Argonaut Insurance has requested review of Referee Browne's order which set aside its denial and which upheld the SAIF Corporation's denial. Argonaut has written to the Board indicating that the exhibits contained in the Board's record on review do not constitute the entire record before the Referee. The Referee who heard this case is no longer an employee of the Hearings Division. Argonaut's attorney submits copies of several cover letters, including enclosures, allegedly submitted to the Referee by both Argonaut's attorney and SAIF's attorney. The enclosures are medical reports which are not contained in the record on review before the Board.

The Board does not have authority to consider evidence not submitted to it as part of the record on review. ORS 656.295(5). However, if the Board determines that a case has been improperly, incompletely or otherwise insufficiently developed by the referee, it has authority to remand. ORS 656.295(5).

Under the circumstances, we conclude that this case was improperly, incompletely or otherwise insufficiently developed by the Referee. We therefore remand to the Presiding Referee for the limited purpose of ascertaining what documents were before the Referee and are therefore a proper part of this record. The Board retains jurisdiction over the request for review. When the Presiding Referee has determined what exhibits constitute the record on review, the case should be returned to the Board. At that time we will set a new briefing schedule.

ORDER

This case is remanded to the Presiding Referee for processing consistent with this order.

ELLEN L. MOLL, Claimant
Jenks & Weinstein, Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 82-06560
September 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Williams' order which set aside its denial of claimant's multiple complaints which include muscle strain and psychological problems and which awarded claimant's attorney a fee of $3000 for services at hearing. The insurer contends that claimant's ongoing psychological problems

are not related to her compensable injury and that the attorney fee is excessive. The Board modifies the order of the Referee.

We make the following findings of fact. Claimant, a process server, suffered a compensable injury in December 1980 when she was assaulted by a person on whom she was serving papers. As a result of the assault, claimant suffered a left ear contusion. She also complained of neck, shoulder and hearing problems. Claimant had preexisting psychological problems for which she had been hospitalized several times and for which she had been treated by Dr. Griffin, psychiatrist, since May 1978.

In June 1981 claimant's assailant went to trial, at which claimant testified, and her assailant was convicted. Thereafter, a pre-sentence investigation was made, during which time the assailant remained free on bail. The assailant was sentenced on August 12, 1981.

Claimant testified that as the time for sentencing approached, she became increasingly upset and fearful that before the sentencing could take place, her assailant would carry out her threats to kill claimant. On August 7, 1981 claimant was hospitalized for gastrointestinal symptoms by Dr. Antoniskis, but she was transferred to the mental health unit where she was treated by Dr. Griffin. The hospital records indicate that claimant was emotionally stressed by both her ongoing divorce and her fears about her assailant's threats. Dr. Griffin left instructions that doors were to remain locked near claimant's room and that visitors were to be monitored.

The records show that on August 12, however, claimant was feeling quite relaxed because her assailant had been convicted and sentenced. On August 13 claimant was discharged from the hospital and Dr. Griffin reported that she had been quite frightened about the trial and the threats but that she had marked relief following the sentencing. Claimant's divorce was final on August 24. The insurer refused to pay for the August 1981 hospital bills.

Dr. Griffin reported that claimant was hospitalized in August 1981 for gastric and abdominal symptoms which were precipitated by her fears of the threats on her life. Dr. Griffin stated that stress from the assault and the ongoing legal processes aggravated her psychological condition which in turn caused increased physical symptoms. As for claimant's condition in June 1982, Dr. Griffin admitted that whether the injury was still contributing to claimant's emotional problems was a confusing issue.

On June 18, 1982 the insurer issued a denial which stated, "we must respectfully deny your claim for further benefits involving any conditions unrelated to your contused ear but will continue to accept responsibility for your left ear contusion." At hearing, however, the insurer's attorney stated, "the terms of the denial essentially indicate that at that point in time further responsibility [for] muscle pull, psysomatic [sic] and psychiatric problems were being denied; thereby, indicating an acceptance of a temporary flareup."

The Referee found that the August 1981 hospitalization was not compensable. Furthermore, the Referee interpreted the denial

letter to deny that claimant suffered any physical or emotional effects of the injury other than a left ear contusion. Finding that some psychological problems resulted from the assault and thus were compensable, the Referee set aside the denial as he had construed it.

We find that claimant's problems in August 1981, whether expressed as physical or emotional, were the result of her psychological condition. Because of our decision below, we need not decide whether claimant's compensable injury was a material contributing cause of her psychological problems at that time.

On review the insurer reiterates its position that the December 1980 incident resulted in a temporary exacerbation of the preexisting psychological disorder. Considering this concession and the insurer's explanation that at the time of the June 1982 denial it was denying further responsibility for claimant's psychological problems, we interpret the denial to deny responsibility for claimant's psychological condition after the date of the denial. Further, we interpret the denial to mean an acceptance for all such conditions before the June 1982 denial. We will not carve the August 1981 hospitalization out of the accepted portion of the claim.

We find that claimant's December 1980 incident was not a material contributing cause of her psychological problems after June 1982. Consequently, we affirm the June 18, 1982 denial.

Regarding the attorney fee question for claimant's attorney's services at hearing, we consider the efforts expended and results obtained. OAR 438-47-010(2). Unquestionably, claimant's counsel has expended a significant amount of time and effort in attempting to have the insurer's denial set aside. However, by virtue of today's order, claimant has obtained compensation only for her August 1981 hospitalization. Applying the standards of OAR 438-47-010(2) and comparing this case with similar cases, we find that an attorney's fee of $750 is appropriate.

ORDER

The Referee's order dated December 30, 1983 is modified. The insurer's June 18, 1982 denial, as interpreted herein, is affirmed. The August 1981 hospitalization is compensable. The attorney fee award for services at the hearing level is $750. This matter is remanded to the insurer for payment of benefits related to claimant's psychological condition through June 18, 1982 and for submission for closure under ORS 656.268. Claimant's attorney shall receive $350 for services on Board review pertaining to the August 1981 hospitalization issue.

DAVID PETSHOW, Claimant
Galton, et al., Claimant's Attorneys
Larry Dawson, Defense Attorney
Schwabe, et al., Defense Attorney

WCB 80-08903 & 81-00263
September 26, 1984
Order on Remand

This case is before us on remand from the Court of Appeals. Petshow v. Ptld. Bottling Co., 62 Or App 614 (1983). There are three parties to this proceeding: claimant and two employers/insurers. All are agreed that the issue on remand is claimant's attorney's fee.

The primary issue throughout the course of this protracted litigation (particularly as it relates to the attorney fee issue presently before us) has been employer/insurer responsibility for payment of compensation in connection with claimant's ruptured Achilles tendon. Ancillary issues concerning the employers/insurers' respective claims processing obligations, claimant's entitlement to be paid and retain interim compensation/temporary total disability benefits, compensation pursuant to ORS 656.245, including related travel expenses, and questions concerning the "subject matter jurisdiction" of the Board, have all been raised and decided at various levels of this proceeding.

The Referee and the Board had determined that payment of compensation for claimant's current condition was the responsibility of Liberty Mutual Insurance Company (Liberty) as an aggravation of claimant's 1976 injury while working for Liberty's insured, Portland Bottling Company. The court reversed the Board's order on the responsibility issue, based upon its determination that claimant had sustained a new injury on July 17, 1980, while working for his brother, J. D. Petshow, who was insured by Farm Bureau Insurance Company (Farm Bureau).

The Referee had awarded claimant's attorney $1,200, payable by Liberty, for prevailing on that insurer's denial and for obtaining reimbursement for the cost of a pair of special shoes purchased by claimant. Although an order had been entered pursuant to ORS 656.307, designating Farm Bureau as the paying agent, the Referee recited in his order that " . . . claimant's role in this matter was not passive as might be implied in a .307 proceeding. Rather the nature of Liberty Mutual's denial raised the necessity for claimant and his attorney to take an active role in these proceedings which in fact was done." Claimant sought penalties and additional attorney fees based upon allegations of unreasonable claims processing on the part of Liberty; however, the Referee declined to grant such relief as to that insurer.

The Referee, however, did impose a penalty based upon his conclusion that Farm Bureau had unreasonably delayed its denial, and in association with this penalty awarded a $250 attorney's fee.

In an Order on Reconsideration, the Referee concluded that he had erroneously declined to order Liberty to reimburse claimant for travel expenses related to medical treatment, and he modified his previous order accordingly. In addition he awarded claimant's attorney an additional fee of $200, to be paid by Liberty, for services rendered in connection with this issue.

On review Liberty raised the issues of employer/insurer

responsibility and the reasonableness of the Referee's award of attorney fees. We affirmed the Referee's order on all issues raised by claimant's request for review and Liberty's cross-request. 34 Van Natta 439 (1982).

On further review to the Court of Appeals, Liberty pursued the responsibility issue (successfully, as indicated above) as well as the attorney's fee issue. Because the court agreed with Liberty that is was not responsible for payment of claimant's compensation, "the order awarding fees [was] reversed." 62 Or App at 622.

Claimant seeks an order directing Farm Bureau to pay the $1,400 attorney's fee that Liberty Mutual was required to pay under the terms of the Referee's orders. In response Farm Bureau asserts, in effect, that although it may have been necessary for claimant to take an active role in the hearing proceeding as a result of Liberty's denial and the issues related to the Liberty claim, no such conclusion is warranted with regard to the Farm Bureau denial, which was concerned only with the question of employer/insurer responsibility. We are advised by Farm Bureau that the $250 penalty-associated attorney's fee imposed by the Referee has been paid.

In its submission on remand, Liberty Mutual has conceded that it should be ordered to pay the $200 attorney's fee awarded in connection with the issue of reimbursement for claimant's travel expenses. Accordingly, the question is whether, considering the efforts expended and results obtained in claimant's behalf on the responsibility issue, as well as the nature of the issues presented by Farm Bureau, an award of attorney fees is appropriate. For the following reasons, we think not.

Farm Bureau's denial was issued by letter dated January 29, 1981. The reason given was that claimant's Achilles tendon rupture was a consequence of his 1976 Portland Bottling/Liberty injury. An order already had been entered by the Compliance Division of the Workers' Compensation Department, pursuant to ORS 656.307, designating Farm Bureau as a paying agent and referring the responsibility issue to the Hearings Division for a determination.

A great deal of effort was expended by claimant's attorney in order to identify the alleged inadequate claims processing on the part of both insurers. On the issue of responsibility, however, we are inclined to agree with Farm Bureau that claimant's participation was more characteristic of a mere witness, as opposed to a party/litigant. Compensability was not at issue, particularly under the terms of the Farm Bureau's denial.

The operative administrative rule is OAR 438-47-090(1), which provides that in proceedings pursuant to ORS 656.307, where the only issue is employer/insurer responsibility, claimant's attorney receives no fee unless he or she "actively and meaningfully participates at the hearing in behalf and in defense of claimant's rights." We have interpreted "active and meaningful" participation in responsibility litigation, at the Referee and Board levels, to mean that the claimant has advocated a position that is adverse to one of the potentially responsible employers or

insurers. Brent Bennett, 34 Van Natta 1563 (1982); Robert Heilman, 34 Van Natta 1487 (1982).

We are unable to conclude that claimant actually took a position at hearing on the issue of employer/insurer responsibility. Indeed, by his opening remarks, claimant's attorney appeared to indicate that the Referee should set aside both insurers' denials and award a reasonable attorney's fee in connection with each. Of course, only one employer/insurer could be found responsible. SAIF v. Webber, 66 Or App 463 (1984).

Under these circumstances, we conclude that claimant's attorney is not entitled to an attorney's fee for services rendered in connection with the issue of employer/insurer responsibility. Claimant did not "actively and meangingfully" participate at the hearing, or at any other level of this litigation, with regard to the responsibility issue. See also Nat. Farm. Ins. v. Scofield, 56 Or App 130 (1982); Hanna v. McGrew Bros. Sawmill, 45 Or App 757 (1980).

ORDER

Liberty Mutual Insurance Company shall pay claimant's attorney $200 as a reasonable attorney's fee in accordance with the terms of the Referee's order. No additional insurer-paid fee is payable to claimant under the terms of this order.

ROBERT E. PONDER, Claimant
Olson Law Firm, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-07403
September 26, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Brown's order which set aside its partial denial of claimant's psychiatric condition or depression and assessed it a penalty and an accompanying attorney's fee for an unreasonable denial.

The Board affirms that portion of the Referee's order which set aside the insurer's partial denial. However, we reverse that portion of the order which assessed the insurer a penalty and an accompanying attorney's fee. We find that the denial was not unreasonable.

The following facts provide a reasonable basis for the insurer's denial. The psychiatric treatment which precipitated the insurer's denial took place approximately six years post-injury, following an approximately three year period in which claimant seldom sought treatment regarding his psychiatric problems. The extent of claimant's care during this three year hiatus was an unspecified amount of treatments for a seven month period at Jackson County Mental Health Clinic. Moreover, at the time of claim closure, some four years before the denial, several of the medical reports seem to indicate that his psychiatric problems related to his compensable head and left shoulder injury had stabilized or resolved. Furthermore, it is well-documented that claimant has a preexisting personality disorder.

ORDER

The Referee's order dated December 19, 1983 is affirmed in part and reversed in part. That portion which assessed the insurer a penalty and an accompanying attorney fee for an unreasonable denial is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the insurer.

OLLIE A. RATER, Claimant
Burt, et al., Claimant's Attorneys
Spears, et al., Defense Attorneys

WCB 82-09665
September 26, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of that portion of Referee Wilson's order which ordered claimant's back injury claim reopened on the basis of aggravation effective November 29, 1982 even though the employer had no notice of a November 1982 aggravation claim until late in the course of the hearing proceedings and never denied a November 1982 aggravation claim. The issue is jurisdictional under Syphers v. K-M Logging, Inc., 51 Or App 769 (1981), and Thomas v. SAIF, 64 Or App 193 (1983).

Claimant worked as a truck driver for this employer from 1966 until early 1982. During this employment he suffered two compensable low back injuries which eventually resulted in awards that total 15% unscheduled disability.

Claimant began working for a different employer as a truck driver in July 1982. On September 27, 1982 claimant was examined by Dr. Murphy, his treating orthopedist, who reported by letter dated September 29, 1982 that claimant was released from working between September 17 and October 4. Dr. Murphy also said that when claimant did return to his regular occupation, he should be limited to a 30 pound weight restriction.

Responding to Dr. Murphy's September 29 letter as an aggravation claim, claimant's pre-1982 employer involved herein issued a denial dated October 12, 1982. That denial states there is no apparent causal connection between claimant's condition in September 1982 as described by Dr. Murphy and claimant's pre-1982 employment. Claimant requested a hearing on that denial.

When the hearing first convened on March 29, 1983, the parties were in some agreement that the information then on hand from Dr. Murphy seemed somewhat confusing and contradictory. With the parties' consent, the Referee first held the record open to obtain another report from Dr. Murphy and subsequently granted the employer's motion to take Dr. Murphy's deposition.

That deposition was taken June 6, 1983. Dr. Murphy then testified that the first date he recommended claimant should not engage in truck driving, even with weight restrictions, was November 29, 1982. This testimony in a June 1983 deposition was the first notice the employer had that claimant's medical condition had supposedly deteriorated even more in November 1982.

In its written closing argument filed with the Referee in

July 1983, the employer contended that this allegation of additional worsening constituted a new aggravation claim beginning November 29, 1982. The employer urged the Referee to refrain from ruling on a new claim which had not even come to its attention until after the hearing that had been held in March 1983.

The Referee found that claimant had established an aggravation beginning November 29, 1982, even though the Referee noted that claimant had not previously presented such a claim to the employer and thus that the employer had never denied such a claim. If we affirmed the Referee's order, we would be taking the illogical action of setting aside an October 1982 denial of a November 1982 aggravation claim.

We do not understand the law to require such a result. In Syphers v. K-W Logging, Inc., supra, the court held that until a claim is accepted or denied, or until the period of time has run during which an employer/insurer may accept or deny, there is no question concerning the claim on which to base a request for hearing, and that a request made during that period of time is premature and of no effect. Subsequently, in Thomas v. SAIF, supra, the court held that an employer/insurer waives its right to complain of defects in the hearing request if it does not object at the time of hearing; the Thomas court interpreted Syphers to hold "that the employer has the absolute right to object and that, if it does so, the Referee may not proceed with the hearing." 64 Or App at 197.

Applying Syphers and Thomas, we here conclude that the Referee's decision concerning the compensability of a possible November 1982 aggravation was premature. The employer did not have notice of claimant's November 29, 1982 aggravation claim until Dr. Murphy's deposition of June 6, 1983. Obviously, no such aggravation claim could possibly have been in issue when claimant's present hearing request was filed on October 21, 1982. Upon receipt of notice of this additional November 1982 aggravation claim, the employer objected to the Referee's jurisdiction over it at the first (and only) opportunity -- in its written closing argument of July 8, 1983. See Thomas v. SAIF, supra. That objection was well taken.

We do not understand claimant to be contending on review that the preponderance of the evidence establishes any basis for setting aside the employer's earlier October 12, 1982 denial of aggravation reopening, which was the actual subject of claimant's October 21, 1982 request for hearing. However, if claimant is now so contending, we disagree.

ORDER

The Referee's orders dated August 17, 1983 and August 26, 1983 are affirmed in part and reversed in part. That portion which set aside the self-insured employer's denial of claimant's aggravation claim and ordered the employer to accept an aggravation claim commencing November 29, 1982 is reversed. The employer's denial dated October 12, 1982 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

HOWARD RICE, Claimant
Richard Condon, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 82-07181
September 26, 1984
Order on Reconsideration

The self-insured employer requests reconsideration of the Board's Order on Review dated August 20, 1984. The employer seeks to have the Board reconsider its order and remand the claim to the Referee for the taking of additional evidence.

The employer's motion for reconsideration and claimant's response thereto have been considered. The motion for reconsideration is granted. On reconsideration, the Board adheres to its prior order and declines to remand to the Referee.

IT IS SO ORDERED.

DELORES SEBASTAIN, Claimant
Christopher Moore, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-08267
September 26, 1984
Order of Dismissal

The insurer has requested review of Referee's order dated August 24, 1984. The request for review was filed with the Board on September 25, 1984, more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The insurer's request for review is hereby dismissed as being untimely filed.

RAY A. STERN, Claimant
Francesconi & Cash, Claimant's Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-05299 & 82-11791
September 26, 1984
Order on Review

Reviewed by Board Members Lewis and Ferris.

EBI requests review of Referee Podnar's order which set aside its denial of claimant's new injury claim, which upheld the SAIF Corporation's denial of claimant's aggravation claim and which awarded claimant's attorney $1,200. Responsibility and attorney's fees are the issues on review.

On the attorney's fee issue, EBI concedes that claimant's attorney is entitled to some fee for having actively and meaningfully participated at hearing. See, OAR 438-47-090. However, it argues that $1,200 is an excessive fee in a responsibility case. We agree. At hearing, claimant's attorney argued that he was entitled to a fee because he had been extensively involved in the case before it became clear that the only issue was responsibility. However, he stated:

> "So, there should be some fee on that. Of course, it should be a reduced fee because when it became clear as a .307 I spent less time on the responsibility issue."

We conclude that a reasonable attorney's fee for claimant's attorney's efforts in this case is $500.

On the responsibility issue, the Referee found EBI responsible under Bauman v. SAIF, 295 Or 788 (1983) because EBI initially accepted the new injury claim and several months later backed up and denied. EBI urges us to repudiate our decision in Cleve A. Retchless, 35 Van Natta 1788 (1983) in which we applied the Bauman doctrine to responsibility cases. We decline to do so.

We note, however, that were EBI's denial not precluded by Bauman and Retchless, we would assign responsibility to SAIF. The evidence establishes an aggravation rather than a new injury.

ORDER

The Referee's orders dated January 13, 1984 and February 8, 1984 are affirmed in part and modified in part. Those portions of the Referee's order concerning responsibility are affirmed. That portion of the Referee's order granting claimant's attorney a fee of $1200 is modified. Claimant's attorney is awarded $500 for services at the hearing level in lieu of the $1200 awarded by the Referee.

ROGER A. AMSBAUGH, Claimant
Francesconi & Cash, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-07357
September 27, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Knapp's order which upheld the SAIF Corporation's denials of chiropractic treatment and affirmed the Determination Order which awarded no permanent disability compensation.

On the medical services question, the Referee first noted that claimant had testified that the disputed chiropractic services provided some relief. The Referee then discussed the decisions of the Court of Appeals in Wetzel v. Goodwin Brothers, 50 Or App 101 (1981), and Milbradt v. SAIF, 62 Or App 530 (1983):

> "Based on these decisions, it would appear that credible testimony that the treatment in some manner helped or was beneficial is sufficient to establish reasonableness and necessity. However, in both of the cited cases, the claimants had previously received an award for permanent partial disability, evidencing the presence of permanent residual symptoms. Here, as determined, the majority medical opinions establish that claimant has no permanent impairment for which treatment is needed, either curative or palliative. Likely, such chiropractic manipulations are to a degree helpful or beneficial to a person, just as other means of soothing one's body would be, such as massages, ultrasound, hot packs, exercises, hot baths, etc. It is not unusual that a particular regimen becomes a beneficial and pleasurable experience, yet it is not a reasonable

necessity that the nature of the injury or the process of the recovery requires. I conclude claimant has not proven that Dr. Powers' chiropractic treatments are a compensable medical service."

We agree with the Referee's analysis.

ORDER

The Referee's order dated January 25, 1984 is affirmed.

GENE H. BURSON, Claimant
Richardson & Murphy, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-03518 & 80-07360
September 27, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

Claimant requests review of Referee Leahy's order which awarded 48° for 15% unscheduled permanent disability in lieu of the 16° for 5% unscheduled disability awarded by Determination Order. Claimant contends that he is entitled to a greater award of permanent disability and a greater period of temporary total disability.

Regarding the permanent disability award, the Board affirms the order of the Referee. The Board modifies the temporary disability awarded by Determination Order, however.

At hearing claimant raised the issue of additional temporary total disability for the period from October 2, 1981 through February 22, 1982. In his order the Referee did not address that issue. On review claimant again raises the issue of his entitlement to this period of temporary disability. The SAIF Corporation does not offer any argument against claimant's entitlement to this compensation and the record supports claimant's position. Therefore, in addition to that awarded by Determination Order, the Board awards claimant temporary total disability for the period from October 2, 1981 through February 22, 1982.

ORDER

The Referee's order dated October 27, 1983 is affirmed in part and modified in part. The Determination Order dated April 2, 1982 is modified to also award claimant temporary total disability from October 2, 1981 through February 22, 1982. Claimant's attorney is allowed 25% of this increased compensation, to be paid out of claimant's compensation. The remainder of the Referee's order is affirmed.

ROBERT E. LEE, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 82-08616
September 27, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The employer requests review of Referee Galton's order which granted claimant an award for permanent total disability. Extent of disability is the only issue on review.

Claimant is a 60 year old man who strained his lumbo-sacral spine in two compensable injuries while working for the same employer. The two injuries worsened claimant's underlying degenerative arthritis. The first injury occurred on June 11, 1979 when claimant stepped backward down a 15 inch step while removing packages from a rack. Claimant received an award of 32° for 10% unscheduled disability for that injury. The second injury occurred on March 23, 1982 when claimant slipped on a wet floor and fell. Claimant received an award of 80° for 25% unscheduled disability for the second injury. Claimant requested a hearing to protest the 25% award.

Claimant's work experience consists of thirty years as a short order cook plus nearly ten years working for the employer. During his ten years with the employer, claimant was a janitor, a grinder, a molder and a radiator painter and packager. Claimant has a tenth grade education and low average intelligence.

On May 10, 1982 Dr. Wade, claimant's treating orthopedist, wrote to Dr. Maskell, claimant's family doctor:

> "I think that your patient...has probably reached the point where he will be unemployable. I doubt whether or not anyone would accept him back under any circumstances in his previous form of employment; certainly would only do so with some reluctance. He has, as you know, severe degenerative low back disease and has had two episodes now with long periods of inability to work. He has previously been judged as having a 10% disability with regards to his low back on the basis of his previous injury. However, he does have, as you know, the degenerative processes that are not included in that determination. That, plus his general medical status, make him unemployable for the general labor market; at least on the surface of things I would think that this is the case."

On August 2, 1982 Dr. Maskell wrote to the employer indicating that he agreed with Dr. Wade.

On August 6, 1982 Orthopaedic Consultants performed an examination of claimant. The panel observed that claimant was obese and that his obesity obviously aggravated claimant's back condition. They noted that claimant had never lost weight, as recommended, and that he had actually gained weight. The panel stated that there was moderate interference from functional

disturbance. They concluded that claimant's overall loss of function was in the mildly moderate range. They opined that claimant was capable of lifting twenty five pounds, of lifting ten pounds repeatedly and could do no repetitive bending, stooping or twisting.

The Callahan Center staff evaluated claimant on November 9, 1982. Dr. Toon, the center medical examiner, noted that claimant's most outstanding feature was his obesity. He opined that based on his examination, claimant was capable of doing light to medium level work.

Claimant was enrolled in a job club following the Callahan evaluation. However, according to the case manager's notes, claimant asked that his file be closed in May 1983 because he was then drawing social security benefits.

At hearing claimant testified that he had searched for work for a short while but had given up his search because it seemed futile. He also testified that Dr. Maskell and several consulting physicians had told him to lose weight.

A vocational expert, Dr. Rollins, testified on claimant's behalf at hearing. He stated that based on the testing done at the Callahan Center as well as his own testing plus the medical reports in the record claimant is unable to sell his services in any regular and gainful occupation.

The Referee concluded that claimant is permanently and totally disabled based on the medical evidence alone. He stated, however, that if claimant is not permanently and totally disabled from a medical standpoint alone, he is permanently and totally disabled when the social and vocational factors are considered. The Referee stated that claimant had satisfied the work search requirement of ORS 656.206(3) by his attempts to obtain employment prior to May 1983. The Referee also stated that claimant would be permanently and totally disabled whether or not he lost weight.

We find that the medical evidence alone does not establish that claimant is permanently and totally disabled. Dr. Wade and Dr. Maskell opine that claimant is unemployable. However, that conclusion is based both on claimant's physical impairment and on the doctors' perception of whether employers would be willing to hire claimant. The willingess of employers to hire claimant is a subject which is not within their expertise as physicians. Furthermore, Dr. Wade's opinion that claimant is unemployable is weakened by the fact that he later agreed with Dr. Toon's assessment. Both Orthopaedic Consultants and Dr. Toon at the Callahan Center state claimant is capable of performing some work. Orthopaedic Consultants opine that claimant can do light work. Dr. Toon opines that claimant can do light to medium work. Dr. Wade indicated in October 1983 that he agreed with Dr. Toon's evaluation.

We also find that claimant has failed to satisfy the work search requirements of ORS 656.206(3). Claimant did not fully cooperate with the job club and withdrew after he obtained social security benefits. Claimant testified that he only looked for work for a short time because he thought it was futile. Such an effort is not sufficient to satisfy the statute when the medical evidence indicates that claimant is capable of light to medium work.

Finally, we find that claimant has unreasonably failed to follow doctors' instructions to lose weight. Nearly every physician in this case has remarked on claimant's obesity and has suggested that claimant lose weight because the obesity aggravates his back condition. The record indicates that during one stay at the Callahan Center, before the second injury, claimant was in a weight loss program and lost a small amount of weight. However, following the second injury he has not lost any weight. Claimant testified that the only program of weight loss he is on is "trying to control my own appetite." An award for permanent disability may be reduced where claimant has unreasonably failed to follow a physician's instructions to lose weight in order to reduce impairment. Nelson v. EBI, 66 Or App 16 (1983), affirmed 296 Or 246 (1984). Accordingly, claimant's award for permanent total disability is reversed.

We conclude that claimant has failed to prove that he is entitled to an award for permanent total disability. However, based on the guidelines contained in OAR 436-65-500 et seq., and comparing this case with other similar cases, we conclude that claimant is entitled to a greater award for permanent partial disability than that granted by the latest Determination Order. We find that claimant would be appropriately compensated by an award of 176° for 55% unscheduled disability in lieu of the 80° for 25% unscheduled disability awarded by the latest Determination Order.

ORDER

The Referee's order dated November 21, 1983 is reversed. Claimant is awarded 176° for 55% unscheduled disability in lieu of the 80° of 25% unscheduled disability awarded by the Determination Order dated September 8, 1982.

JESSE H. LEYVA, Claimant
Jack Ofelt, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-04214
September 27, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Braverman's order which granted claimant an award for permanent total disability. Extent of disability is the only issue on review.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated January 24, 1984 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the SAIF Corporation.

Board Member Barnes Concurring:

This is a rather graphic example of what is wrong with Gettman v. SAIF, 289 Or 609 (1980), which tells us that disability has to be rated as of the time of hearing without regard for retraining prospects.

After sustaining a fairly serious injury, claimant eventually

became involved in Oregon's version of vocational retraining. I hope there are retraining success stories in Oregon, but it seems that the only ones that reach this level of the litigation system are closer to the "horror story" end of the spectrum.

This is one of the more horrible stories. This claimant was caught in a bureaucratic (and possibly also philosophical) cross-fire between the Vocational Rehabilitation Division of the Department of Human Resources and the Field Services Division of the Workers Compensation Department. Even the SAIF Corporation, which by (probably unfair) reputation is rather indifferent to the plight of injured workers, grew sufficiently concerned that it retained a private rehabilitation consultant to evaluate claimant's situation.

It was largely fortuitous that this case came on for hearing before SAIF's consultant, Mr. Machorro could do much. In any event, Mr. Machorro testified at hearing, generally offering the following assessment: (1) claimant was probably then unemployable; but (2) rehabilitation and retraining efforts had not yet been given a fair chance of getting claimant back to work. The full Board has discussed this case; I gather we all agree with Mr. Machorro that it is clearly premature to give up on any possibility of getting claimant back to work and, instead, to throw him on the human scrap heap with a total disability award. But that kind of probable disservice -- both to claimant himself and also to Oregon's industrial future -- seems to be compelled by the Supreme Court's Gettman decision.

Solely based on that understanding of the rules that we must comply with, I join the prevailing order to affirm the Referee.

DAVID SHTERNSHTEYN, Claimant
Jack Ofelt, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 83-04245
September 27, 1984
Order on Review

Reviewed by Board Members Lewis and Barnes.

Claimant requests review of Referee Pferdner's order which affirmed an August 24, 1982 Determination Order that did not award him scheduled permanent partial disability for his right arm injury. The insurer cross-requests review, contending it is entitled to an offset against future compensation for overpayment of temporary total disability benefits.

The Board affirms that portion of the order regarding the extent of claimant's disability.

We believe that the insurer has met its burden of proving an overpayment. A claims representative for the insurer testified that the insurer had paid approximately six more weeks of time loss than was required. After adjusting for underpaid temporary partial disability benefits, the representative testified that the overpayment totalled $1453.79. This testimony was neither challenged nor rebutted.

Accordingly, we find that the insurer is entitled to an offset of $1453.79 against future benefits that may become due and payable.

ORDER

The Referee's order is affirmed in part and modified in part. The insurer is authorized to an offset of $1453.79 to be applied against future benefits for temporary and permanent disability. The remainder of the Referee's order is affirmed.

SANDRA AUSTIN, Claimant
Quintin Estell, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-04705
September 28, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of that portion of Referee Thye's order which set aside its denial of claimant's aggravation claim. Claimant cross-requests review of that portion of the Referee's order that refused to rate the extent of claimant's disability. The issues are: (1) Compensability of the aggravation claim; and, (2) the extent of claimant's permanent disability prior to the alleged aggravation.

We note at the outset that this case presents a procedural irregularity that complicates our review. The electronic recording of claimant's testimony on direct and cross examination at the hearing was inadvertently erased before the transcript was prepared. At the request of the parties, we remanded this case to the Referee for the purpose of retaking claimant's testimony. Sandra Austin, 35 Van Natta 1577 (1983). Rather than retaking claimant's testimony, counsel for the parties agreed that the Referee would read his hearing notes into the record, and that the transcript of that proceeding would constitute claimant's "testimony" for the purposes of review.

While a claimant's testimony is statutorily sufficient to show worsening of a condition in order to establish an aggravation claim under ORS 656.273, Garbutt v. SAIF, 297 Or 148 (1984), the trier of fact may assign to the testimony the weight, if any, to which it is entitled. We are unable in this case to review claimant's actual testimony. However, upon remand, the parties stipulated that the Referee's recitation of his notes of claimant's original testimony, with the addition of several statements, could stand as claimant's testimony in lieu of her being recalled to the witness stand. The parties acknowledged that the statements attributed to claimant and read into the record on remand, are consistent with claimant's original testimony.

Claimant suffered a compensable injury to her back and neck as the result of an automobile accident on September 12, 1979. For the next year she was treated by Dr. Glubka, a chiropractor.

On October 10, 1980 claimant was examined at the insurer's request by Dr. Stanley, an orthopedist, who noted claimant's subjective complaints of pain, but could find no objective signs to substantiate them. He recommended a physical rehabilitation program, which claimant declined. In Dr. Stanley's opinion, claimant would have no permanent disability.

In November 1980 claimant saw Dr. Fechtel, another chiropractor. Dr. Fechtel noted some minor limitation of range of

motion, but could otherwise find no objective signs of injury to explain claimant's subjective complaints. Dr. Fechtel recommended less frequent chiropractic care. He also noted signs that suggested an emotional involvement.

Claimant continued to treat with Dr. Glubka. His reports of February 5, 1981 and May 7, 1981 report claimant's subjective complaints without pointing to any objective findings that would explain them.

Dr. Martens, orthopedist, examined claimant at the insurer's request in June 1981. In his opinion, claimant was stationary. He found minimal impairment, and recommended that claimant return to clerical work with some restrictions on reaching, bending, twisting and lifting. Dr. Glubka disagreed with Dr. Martens in most of his material statements, but did not explain the bases for his disagreement.

In June 1981, claimant moved and began treating with Dr. Clibborn, another chiropractor. In July 1981 Dr. Clibborn was provided with copies of Dr. Martens' report and Dr. Glubka's response to it.

Claimant's claim was closed by a Determination Order dated August 14, 1981, which granted claimant no award for permanent disability.

Dr. Clibborn issued his first report October 10, 1981. The report states that claimant continued to have upper back and neck pain associated with headaches. He opined that claimant would have some permanent disability.

In February 1982 claimant was examined by Dr. Kelley, a chiropractor, at the insurer's request. Dr. Kelley, after reciting a thorough history and impression of his physical examination of claimant and reviewing x-rays taken of claimant, commented that claimant's subjective complaints were "considerably high when compared on a correlative basis with the objectivity...," which he characterized as "indeed essentially negligible...." In his opinion, claimant's impairment as a result of her injury was "very minimal," and was primarily based upon unsubstantiated subjective complaints.

Claimant began working for another employer in a clerical position in June 1982. On August 4, 1982 Dr. Clibborn reported that claimant was experiencing an increase in her neck pain and headaches, which he felt was probably due to her new employment. He did not report any objective bases for claimant's new complaints. In addition to the reported recurrence of her past symptomology, Dr. Clibborn noted that claimant also complained of pain radiating into her arms and hands.

Claimant left work on October 14, 1982, and her aggravation claim was filed October 15, 1982. The insurer denied the aggravation claim December 13, 1982.

In November 1982, prior to the denial of her aggravation claim, claimant was examined by yet another chiropractor, again at the insurer's request. Dr. Bolin found no objective signs to corroborate claimant's reported level of pain and alleged

impairment. He noted an obvious lack of cooperation during his examination, and commented that claimant exhibited a very strong emotional involvement with possible hysteria. Dr. Bolin's opinion was that claimant had no residual impairment related to her 1979 injury that would interfere with her employment or require curative treatment.

In January and May of 1983 claimant was examined by Dr. Tsai, a neurologist, who reported finding no objective signs to substantiate claimant's complaints. He ultimately stated that claimant was medically stationary, that she would be likely to experience pain indefinitely and might require intermittent palliative care.

Claimant's testimony, as summarized by the Referee, was that she had constant pain in her neck and low back, headaches, and pain and burning in her legs since the 1979 accident. She worked until February 1980 when she was terminated from her job because of the amount of time she was taking off for medical care. By June 1982 her neck pain had gotten better, but was not gone completely. She described some of her limitations as being unable to use a regulation weight bowling ball, water ski or dance. Before beginning her new job in June 1982 she saw Dr. Clibborn twice weekly. She would stiffen up if she missed her appointments.

According to the Referee's summary, after she began her new job claimant's headaches returned, her neck became stiff and sore again, her low back swelled and she began suffering spasms in her right arm. At the time of the hearing claimant was seeing Dr. Clibborn three times weekly.

The Referee made no specific finding as to claimant's credibility.

On the issue of the compensability of claimant's aggravation claim, we are not persuaded that claimant's original condition has worsened since the last arrangement of compensation, August 14, 1981.

The transcript of the Referee's recollection of claimant's testimony, which the parties agreed was accurate, at best shows a continuation of the same subjective complaints over a roughly three and one-half year period. We do not find Dr. Clibborn persuasive. At best, his reports are an echo of claimant's subjective complaints. He offers no objective explanation that tends in any way to correlate with claimant's description of her pain, and there is no evidence that Dr. Clibborn has ever changed his treatment approach with claimant.

The six other doctors, three medical doctors and three chiropractors, who examined claimant are unanimous in their opinions that there are no objective findings to substantiate claimant's complaints, or to substantiate the alleged worsening. The medical evidence offered by these six doctors indicates that claimant's complaints have little, if anything, to do with the 1979 injury. We find that claimant has failed to sustain her burden of proving the compensability of her aggravation claim by a preponderance of the evidence.

On the issue of the extent of claimant's permanent disability, we are persuaded by doctors Stanley, Fechtel, Martens,

Kelley, Bolin and Tsai that claimant has no permanent impairment caused by the 1979 injury.

ORDER

That portion of the Referee's order setting aside the insurer's denial of claimant's aggravation claim is reversed. The insurer's denial of claimant's aggravation claim is reinstated. The remainder of the Referee's order is affirmed.

DONALD R. CLARK (Deceased)
Steven Hutchison, Attorney
SAIF Corp Legal, Defense Attorney

Third Party 84007
September 28, 1984
Order on Reconsideration

The Board issued its Order on Review on July 20, 1984 denying claimant's request for an extraordinary attorney fee. In the order we advised claimant's counsel that we would reconsider our decision if we were presented with the retainer agreement and an affidavit specifically setting forth the basis for claimant's request.

On September 10, 1984 the Board received the retainer agreement, an affidavit from claimant's counsel and a request that we reconsider our decision. The affidavit lists several factors which claimant contends justifies an award of an extraordinary attorney fee. These factors include:

1. Over three and one half years of representation, requiring the investment of over 300 hours of time.

2. Extreme difficulty in reconstructing the events which resulted in the fatality, including: (1) extensive interviews with family friends in order to establish the deceased's method of operation and reputation for safety and (2) the location of expert witnesses to testify concerning safety regulations, good safety practices on site, general logging procedures, and to furnish their opinion as to the probable cause of the accident. These experts were critical to claimant's case because they contradicted both the official investigative report, which concluded there was no fault or negligence, and the two eyewitnesses.

3. A six-day trial.

4. A jury verdict with a good result of $265,000, less 25% comparative negligence on the part of the deceased.

5. The advancement of substantial costs in excess of $3,000 and the guarantee of expert witness fee payments due to the extremely limited financial resources of the widow.

The request for reconsideration is granted. Without question, claimant has listed a number of factors which weigh in favor of granting counsel an extraordinary fee. However, after reviewing this matter and comparing this case with similar cases concerning requests for extraordinary fees, we conclude that an extraordinary attorney fee is not justified in this instance. See Leonard F. Kisor, 35 Van Natta 282 (1983); John Galanopoulos, 34 Van Natta 615 (1982), 35 Van Natta 548 (1983). Therefore, on reconsideration, the Board adheres to its former order which we hereby republish by this reference.

IT IS SO ORDERED.

JOHN P. COOK & DONALD S. COOK, Employer
(dba Cook's Forest Products)
Cash Perrine, Attorney
Roberts et al., Attorneys
Carl M. Davis, Asst. Attorney General

WCB 82-04472
September 28, 1984
Order of Dismissal

The putative noncomplying employer requests review of Referee Mason's order which upheld an order of the Workers' Compensation Department which found that the employer was a noncomplying employer. The only issue before the Referee was the noncomplying status of the putative noncomplying employer. No matters concerning a claim were implicated. We have held today that under the law in effect at the time review was requested in this matter, the Board did not have jurisdiction to review the decision of a Referee in a case involving the issue of noncomplying employer status which did not involve any issues concerning a claim. Gary O. Soderstrom, 36 Van Natta 1366 (decided this date.) Accordingly, we must dismiss this case for lack of subject matter jurisdiction.

We note that it is unfortunate if the statement at the conclusion of the Referee's order that appeal should be to the Board misled the employer. However, our jurisdiction is solely statutory and incorrect statements of appeal rights cannot expand our jurisdiction.

ORDER

The employer's request for review is dismissed for lack of subject matter jurisdiction.

MICHAEL G. DANGERFIELD, Claimant
Bischoff, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 83-08496
September 28, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Quillinan's order which affirmed a Determination Order which had awarded claimant 16° for 5% unscheduled disability for injury to his low back.

Before the industrial injury here in question, claimant suffered a lumbosacral sprain in 1975, necessitating 30 days time loss and two months of modified light work. Nagging low back pain persisted, resulting in occasional time loss and chiropractic treatment. After the 1975 injury claimant transferred to a position that involved lighter work. Also before the industrial injury here in question, claimant was involved in a car accident in 1979, which caused low back pain and spasms. Claimant missed about one week of work as a result of this accident.

The present industrial injury dates from May 1982 when claimant sustained a ruptured L5-S1 disc while shoveling wet sawdust. A discectomy was performed the following month. On October 18, 1982 claimant was released to modified work with a restriction against lifting over 30 pounds. He was released for full work on January 15, 1983 with restrictions of no lifting, carrying, pushing or pulling of over 75 pounds, more than occasional lifting of over 50 pounds or more than occasional bending, twisting, crawling or climbing of ladders.

Claimant testified that his present problems consist of a constant aching pain of varying severity in his lower back and radiating into both legs. He plans both his work and leisure activities to avoid overtaxing himself and, to the extent that he is generally successful in this effort, it would seem that little of his pain is truly disabling. For example, he missed only one day of work from January 15, 1983 through March 1, 1984, the date of the hearing.

Claimant is 30 years old and has an eleventh grade education. He has worked briefly as a light mechanic and at various jobs with his present employer in a flakeboard plant. He continues to perform essentially the same duties as before the injury. His wages have increased. He testified that he had never had a job that he could not learn by doing.

Claimant apparently had very successful surgery which produced a very good result. The medical limitations that have since been imposed are certainly not severe. Claimant's pain is rarely truly disabling, at least in the context of his present medium-to-light duty job. Nevertheless, we think that claimant's loss of earning capacity in the broad field of industrial occupations exceeds the 5% award granted by the Determination Order. Claimant certainly would have serious difficulty performing most jobs at the heavy end of the spectrum.

It is possible that a portion of claimant's present problems relate back to the prior 1975 or 1979 injuries, but comparing claimant's apparent earning capacity just before the 1982 industrial injury with his apparent present earning capacity leads us to conclude that an award of 32° for 10% unscheduled disability would be more appropriate.

The rating of disability is sufficiently imprecise and subjective that, generally speaking, the Board is not willing to "tinker" with prior awards by increasing or decreasing by amounts as small as plus-or-minus 5%. All generalizations, however, can and should be subject to reasonable exceptions and we think this case is exceptional because of the strength of our conviction that claimant's award should be increased and because, looking at it from claimant's point of view, an award of 5% more disability is really an increase of 100% over what he has received to date.

ORDER

The Referee's order dated March 21, 1984 is modified. Claimant is awarded 32° for 10% unscheduled disability in lieu of all prior awards. Claimant's attorney is allowed 25% of the increased compensation granted by this order as and for a reasonable attorney fee.

JAMES DANIELS, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01500
September 28, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The SAIF Corporation requests review of that portion of Referee Shebley's order which held that claimant had not waived his right to litigate the extent of disability awarded by the April 21, 1982 Determination Order by requesting and accepting a lump sum payment of the award granted by that order. Claimant cross-requested review of those portions of the Referee's order which: (1) upheld SAIF's denial of his April 12, 1983 aggravation claim; and (2) awarded claimant 320° for 100% unscheduled permanent partial disability for his low back and left shoulder plus 37.5° for 25% loss of use of function of his right leg in lieu of the award made by the April 21, 1982 Determination Order. Claimant seeks permanent total disability.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated November 30, 1983 is affirmed. Claimant's attorney is awarded $450 for services on Board review, to be paid by the SAIF Corporation.

Board Member Barnes Concurring:

ORS 656.304 provides "that the right of hearing on any award shall be waived by acceptance of a lump sum award by a claimant where such lump sum award was granted on his own application under ORS 656.230." Long ago, in a case involving an illiterate Spanish-speaking claimant, the Board stated that ORS 656.304 "would have little effect if its clear language could be ignored upon a plea of ignorance." Alejandro Pagan, 3 Van Natta 182 (1969).

More recently, I understand the Court of Appeals to have ruled that a putative written waiver of hearing rights, executed by a claimant in order to obtain lump sum payment of an award, is not really a waiver if the claimant testifies that he was ignorant of the contents of the document and a Referee finds the claimant credible. Landriscina v. Raygo-Wagner, 53 Or App 558 (1981). It would appear that Landriscina thus creates exactly the situation the Board sought to avoid 15 years ago in Pagan: ORS 656.304 has "little effect" because "its clear language" can "be ignored upon a [successful] plea of ignorance."

I join in accepting claimant's plea of ignorance in this case notwithstanding ORS 656.304 only because I understand that result to be compelled by Landriscina.

JEANNINE M. KEENE, Claimant
Francesconi & Cash, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-03876
September 28, 1984
Order on Review

Reviewed by Board Members Ferris and Barnes.

The insurer requests review of Referee Shebley's order which set aside its denial of claimant's occupational disease claim for stress. On review, the insurer contends that the claim does not meet the standard for compensability as set forth in McGarrah v. SAIF, 296 Or 145 (1983). We agree and reverse.

Claimant is a 23 year old former accounts receivable clerk for a dental supply company. Claimant and her supervisor, Ms. Clark, were the only employees in the bookkeeping department. Ms. Clark and claimant had a number of disagreements. Between January 1980 and December 1982, Ms. Clark reprimanded claimant several times for tardiness, inefficiency and personal telephone calls. Most of these reprimands were frustrating to claimant because she felt they were unjustified.

In 1981 claimant began consuming alcohol every night after work to relieve the tension. Her consumption significantly diminished in April 1982 when she met the man she subsequently married.

Off and on during 1980, 1981 and 1982 claimant experienced money problems. In February 1982 she moved back to her parents' home where she was placed under a curfew. Claimant testified that the curfew did not affect her congenial relationship with her parents.

In late 1981 claimant began treatment for cervical warts. Initially, medication was administered, but eventually a freezing technique was employed. By February 1982 the condition had cleared. During this time claimant had noticed a weight gain, but was not concerned.

In mid-September 1982, two days before her wedding, claimant learned that she had a "bad" pap smear indicating there was a possibility of cervical cancer. In addition, it was possible she would not be able to have children. In November 1982 she underwent cryosurgery, a technique which freezes the cervix. After the surgery she was advised to refrain from sexual activity for 30 days. Understandably, these revelations and procedures were quite distressing to claimant and her husband.

By approximately December 15, 1983, claimant learned that she had "stage two" cervical cancer, a non-advanced stage of the disease. This news came as a great relief to claimant and her husband.

On December 23, 1982 claimant and her husband attended a holiday celebration with several other employees, including Ms. Clark. At that gathering Ms. Clark praised claimant's work. In addition she told claimant's husband that claimant was "an asset" to the business.

The next business day Ms. Clark advised claimant that she was being placed on a 30-day probation. Claimant was also advised

that in two weeks prospective replacements would be interviewing for the position in case claimant was terminated. Claimant was greatly distressed by this news. Her husband picked her up from work early, noting that she was visibly upset, crying and trembling. Claimant never returned to her job.

Claimant spent the next month in her apartment. On January 31, 1983 she sought treatment from her family doctor, Dr. Trostel, complaining of anxiety resulting from her termination. Dr. Trostel prescribed medication. Claimant did not seek treatment earlier because she "did not want anything to do with anybody." Claimant's husband testified that he wanted claimant to relax and get her mind off the termination during this period. He stated, "Emotionally, she couldn't handle it."

On February 23, 1983 claimant submitted her claim, contending she suffered "job stress" as a result of "harassment and unfair termination." The insurer denied the claim on March 15, 1983 stating there was no medical evidence supporting the claim. Additionally, the insurer contended that off-the-job stresses were the major contributing factor for claimant's condition and that claimant had failed to notify her employer in a timely fashion. Claimant requested a hearing.

On March 18, 1983 claimant was examined by Dr. Colistro, licensed psychologist. Dr. Colistro, claimant's treating psychologist, reported that claimant's symptoms indicated a generalized anxiety disorder. Dr. Colistro opined that "[I]n the absence of any other significant psychosocial stressors in [claimant's] life, her condition is seen as being one hundred percent job-related." Dr. Colistro's report does not mention claimant's cervical cancer problems, the prohibition against sexual activity and the possibility of not bearing children. Claimant testified on direct examination that "To my knowledge, I think I did" tell Dr. Colistro about the possible cervical cancer diagnosis. During cross examination, claimant insisted she advised Dr. Colistro of the cervical cancer treatment, but did not tell him of her prior cervical warts and surgery.

In June 1983 claimant was examined by Dr. Parvaresh, psychiatrist. Dr. Parvaresh diagnosed an underlying anxiety tension. The doctor defined this condition as a propensity to experience anxiety or nervousness in relation to stress. Dr. Parvaresh testified that claimant's anxiety developed years before and was part of her personality makeup. It was always present and made symptomatic by stress. Dr. Parvaresh opined that the "job" stress did not significantly worsen claimant's preexisting condition and that any stress experienced by a person with claimant's condition which goes "beyond their coping mechanism can cause more symptomatic manifestation of the illness."

Applying the McGarrah standard, the Referee found that claimant was subjected to stress at work. In reaching his conclusion, the Referee assigned a great deal of weight to the testimony of claimant's husband, whose honesty impressed him. Dr. Colistro's opinion, as treating physician, was given "somewhat greater" weight than that of Dr. Parvaresh. Moreover, the Referee noted that Dr. Parvaresh's opinion could be interpreted to support the theory that claimant's preexisting, but asymptomatic, condition became symptomatic as a result of claimant's work.

Finally, the Referee acknowledged that the "cancer scare" was a stressful, non-work related event. However, there was no evidence that claimant suffered symptoms prior to learning that the condition could be effectively treated. The Referee believed that claimant candidly testified that she did tell Dr. Colistro, or his assistant, about the non-work stressors.

In McGarrah v. SAIF, 296 Or 145 (1983), the court found that in order for a stressful condition to be compensable, the on-the-job stressful conditions must actually exist, that is, from an objective standpoint the on-the-job stress must be real as opposed to imaginary. Furthermore, the employment conditions, when compared to non-employment conditions, must be the major contributing cause of the mental condition.

Although we agree that claimant was subjected to real stress which actually existed at her place of work, we are not persuaded that claimant's work stress was the major contributing cause of her mental condition. Claimant experienced a number of significant off-the-job stressors during the time in question. Several of these stressors involved life-changing, possibly life threatening, experiences. Had Dr. Colistro mentioned these stressful events and then dismissed them as contributing factors, we likely would reach a different conclusion today. Particularly because claimant did not seek treatment until after: (1) she had left her job and (2) had learned that her cancer had been identified in an early treatable stage.

However, Dr. Colistro did not mention any of these stressors in detailing claimant's history. Moreover, he qualified his opinion, stating, "[I]n the absence of any other significant psychosocial stressors...her condition is seen as being one hundred percent job-related." Such a qualification suggests to us that, contrary to claimant's testimony, Dr. Colistro was unaware of any of claimant's off-the-job stressors. Consequently, we attribute little probative weight to Dr. Colistro's opinion.

In addition, we find Dr. Parvaresh's opinion that claimant suffered from an underlying anxiety tension condition more persuasive. However, we reject that portion of his opinion that suggests claimant's condition might have become symptomatic as a result of claimant's work stress because the record suggests that Dr. Parvaresh was also unaware of claimant's "cervical cancer scare" and its possible ramifications.

For the above reasons, we find that claimant has failed to meet her burden of proving compensability of her stress claim.

ORDER

The Referee's order dated January 17, 1984 is reversed. The insurer's denial dated March 15, 1983 is reinstated and affirmed.

LEROY E. LEEP, Claimant
James P. O'Neal, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 83-10391
September 28, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

Claimant requests review of Referee Danner's order which upheld the SAIF Corporation's denial of claimant's aggravation claim. Claimant argues that his low back condition has worsened since a stipulated order dated September 26, 1983, which is the last arrangement of compensation.

Claimant injured his low back in September 1977. The claim was denied by SAIF and claimant requested a hearing, which was held before Referee Peterson in December 1978. Referee Peterson found the claimant not credible and upheld the denial. In July 1979 we reversed Referee Peterson and set aside the denial. 27 Van Natta 451 (1979).

In December 1981 Dr. Bert performed a lumbar fusion. In March 1983 Dr. Bert noted that claimant continued to have subjective complaints but few objective findings. He opined that claimant not return to truck driving, and recommended that he be retrained to perform a job "where there is standing, a limited amount of sitting and no frequent bending or stooping." In July 1983 Dr. Bert wrote that claimant could return to "light to moderate work and could do a driving job with no lifting and a very soft riding truck." In September 1983 the stipulated order awarded claimant an additional 10% unscheduled disability, for a total disability award of 50% unscheduled disability.

Claimant returned to work driving a chip truck following the Stipulated Order. The job consisted of driving for up to nine hours per day in a truck with an air cushioned seat, climbing up and down ladders, rolling and unrolling a tarp and walking on the load of wood chips. On the third day after returning to work claimant did not finish his shift; he never returned to driving the chip truck. Dr. Gurney reported on October 20, 1983 that claimant said he was experiencing increased pain. Dr. Gurney opined that claimant could not do heavy work such as truck driving if it involves stooping, bending, lifting, or prolonged driving. Dr. Gurney stated that claimant was totally disabled and unable to work. Claimant's attorney requested a hearing three days after Dr. Gurney's report. SAIF never formally denied the aggravation claim, but at hearing the parties agreed it was in denied status.

On January 5, 1984 Dr. Gurney reported that he believed claimant's back had become more swollen and irritated by driving the chip truck. He admitted he did not have objective evidence and was forced to rely on claimant's subjective complaints.

At hearing, the Referee found that claimant had failed to sustain his burden of proving that his compensable condition had worsened since the last arrangement of compensation. We agree.

In order to prove a compensable aggravation, a claimant must prove that his condition has worsened and that the compensable injury is a material cause of the worsening. A physician's report is not necessarily essential in order to sustain the burden of

proving a worsening, but the "worker's or other lay testimony may or may not carry the worker's burden." Garbutt v. SAIF, 297 Or 148, 151 (1984). We are not persuaded in this case that claimant's testimony is sufficient to sustain his burden of proof.

We note that there is some question regarding claimant's credibity in view of the Referee Peterson's finding in the prior proceeding. However, Referee Danner found claimant credible in this proceeding. Nevertheless, approaching credibility as a "shades of gray" rather than a "black or white" matter, some doubt remains.

Moreover and more importantly, even accepting claimant's testimony in the light most favorable to him, we find that he has failed to sustain his burden of proof. Claimant testified that he did not finish his shift the third day back at work because he did not feel like finishing the shift. He testified he would have returned the next day, but was never called by the chip truck company. He testified that after the third day his back felt stiff and sore. He testified that he is taking more pain medication than prior to working those three days, that he wears his back brace more hours than he did previously, and that he is not able to walk as far.

Claimant previously received awards for unscheduled low back disability that total 50%. Some waxing and waning of symptoms is to be expected in one who has 50% back disability. Such fluctuations may be, and usually are contemplated in awards which take into account disabling pain. Charlotte Clemmer, 36 Van Natta 753 (1984); see also Maarefi v. SAIF, 69 Or App 427 (1984). Repeatedly and long before the alleged aggravation here in issue, claimant's doctors advised him to avoid work which requires long periods of sitting or more than light efforts. Claimant had at most a symptomatic increase in pain, and understandably so, when he attempted to perform a job which required hours of sitting as well as climbing, walking on bark chips and rolling and unrolling a tarp on top of the chips. Because we think this kind of flare up of pain must have been contemplated at the time of claimant's previous awards of compensation, we conclude that he has failed to prove that his condition is any worse than it was on September 23, 1983, the date of the last arrangement of compensation.

ORDER

The Referee's order dated February 1, 1984 is affirmed.

GLORIA L. MATHIESON, Claimant
Malagon, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-07116
September 28, 1984
Order on Review (Remanding)

Reviewed by Board Members Lewis and Barnes.

The insurer requests review of Referee Foster's order which set aside its partial denial of responsibility for claimant's psychiatric treatment. On review, the insurer contends claimant has failed to establish that her psychiatric treatments are causally related to her 1980 compensable left forearm (wrist) condition. We agree and reverse the Referee's order.

Claimant was 29 years of age at the time of hearing. She filed her claim in November 1980, contending the freezing environment, encountered while working as a forklift driver at a frozen food warehouse, had caused pain and swelling in both of her hands. After receiving various diagnoses and conservative treatment, it was recommended that she avoid extremely cold temperatures. However, claimant returned to her forklift duties. Her claim was closed in November 1981 with no permanent disability award and one day of time loss.

From July 27, 1982 until February 1, 1983 claimant sought treatment on approximately six occasions from James E. Pittenger, M.S. At the time of her initial consultation, claimant indicated that her principal problem was depression from work problems.

On January 5, 1983 claimant began treatments with Dr. Wichser. Claimant complained of pain in her hands and wrist, headaches, stomach pains, nausea and soreness in her shoulders and neck. Claimant also noted that, "I feel stressed from the pain and worry about my physical condition." Dr. Wichser diagnosed possible thoracic outlet syndrome with muscle spasm and probable situational depression. By late January 1983 Dr. Wichser had released claimant for light duty line work where she would not be performing repetitive motions. Dr. Wichser additionally noted that claimant had requested a daytime job, rather than night or swing shift.

In March 1983 claimant was interviewed by Dr. Radmore, psychiatrist, who opined that claimant experienced a cyclic mood disorder ("so-called manic-depressive illness") which predated her employment. Dr. Radmore noted that claimant had a long family history of mental breakdowns and had undergone a previous psychotic experience. Dr. Radmore identified a tendency toward grandiosity and recommended if stress-related claims were raised, claimant should be given a complete evaluation to clarify the stressful effect of adapting to lighter work. Dr. Radmore reported that claimant had not been working in the freezer since the end of December 1982, but that a transfer to "swing shift" had been difficult for her physically and emotionally. Apparently, the transfer was preventing claimant from maintaining a close relationship with a female friend and her daughter. In completing a demographic questionnaire, claimant wrote that she considered herself married to her friend. Claimant also stated that a supervisor was purposely scheduling her for duty the supervisor knew claimant could not perform.

After several months of treatment, Dr. Wichser noted in May 1983 that claimant had fired all practitioners who attempted to help her in methods which appeared at all threatening, had set up multiple "no-win" situations and according to her own statements, simply desired to be off work totally. The doctor noted that claimant possessed multiple work skills and physical capabilities in that she had recently won a forklift driving contest which required the use of numerous pieces of machinery. Dr. Wichser suggested further psychiatric consultation.

In June 1983, on referral from a consulting orthopedist, claimant commenced treatments with Dr. Carter, psychiatrist. Claimant complained of her severe pain problems and expressed concern over where she would be able to work. Dr. Carter noted

that claimant related that although she liked her job, the repeated contact with cold temperatures was producing too much pain to continue working. Dr. Carter diagnosed psychogenic pain disorder and estimated claimant would require six months of treatment.

In July 1983 the insurer denied responsibility for the psychiatric treatments, contending her condition did not arise out of her employment and that the condition predated her employment. Also in July 1983, a Determination Order awarded claimant 5% permanent disability for her left forearm. Claimant requested a hearing, contending her condition was not medically stationary and that the denial should be set aside. Alternatively, she contended she was entitled to additional permanent disability.

In September 1983 claimant was examined by Dr. Parvaresh, psychiatrist. The doctor noted that claimant was currently asymptomatic, but advised that this was not unusual in manic-depressives. Dr. Parvaresh further noted that claimant had an ongoing preexisting anxiety tension as a result of a basic personality makeup and an attempt to relate to others. In addition, claimant had substance abuse problems in the form of heavy exposure to marijuana and cocaine.

Dr. Parvaresh opined that claimant's personality make-up, possible manic-depressive tendency or the presence of substance abuse did not have anything clinically to do with her compensable injury. The doctor considered claimant's injury insufficient to justify her current treatment in that her limitation did not prevent her from continuing forklift duties, as long as she avoided exposure to cold temperatures.

Dr. Carter disagreed with Dr. Parvaresh. Dr. Carter noted that Dr. Parvaresh's examination took place 10 days after claimant had become asymptomatic and discontinued treatments with him. Further, Dr. Parvaresh had failed to address the relationship of claimant's psychiatric condition to her chronic pain. Therefore, Dr. Carter questioned the retrospective nature of Dr. Parvaresh's opinion. Dr. Carter continued to opine that claimant's psychogenic pain disorder was substantially related to her experience of thermal exposure on her job.

At hearing, claimant described the various jobs she was assigned beginning in January 1983. Initially, she worked in a swing shift position, answering approximately six phone calls in an eight hour shift. She was then assigned to washing windows in the lunch room, a two hour job which she was encouraged to stretch into eight hours. Both of these jobs were extremely frustrating to claimant, who liked to work hard and fast. Next, claimant was assigned to the production line where she inspected boxes. Claimant was then asked to "hold back a bunch of boxes," but could not perform this job due to the wrist pressure. Finally, claimant was transferred to making boxes, which further exacerbated her pain. In June 1983, having no other suitable position available, claimant was placed on time loss.

Claimant testified that she suffered a psychotic breakdown in July 1978, but required no hospitalization. The breakdown was preceded by going without sleep for a week, "being happy" and "smoking marijuana." During this episode claimant experienced feelings of Godliness. In addition to her daily marijuana use, claimant has used cocaine, amphetamines, quaaludes and LSD.

Claimant also was experiencing depression concerning her personal relationships when she sought treatment from Mr. Pettinger in July 1982. Her relationship with a female companion was deteriorating at that time, finally ending in October 1982. However, in September 1982 a relationship with another woman began. Additionally, in February 1983 claimant expressed concerns about introducing her new companion to her family.

The Referee found claimant's psychiatric treatment compensable. Despite her past psychiatric history and drug use, the Referee relied on Dr. Carter's opinion to find that claimant's work exposure was a material contributing factor to her present condition. Since the claim was reopened for further psychiatric treatment, the Referee declined to rate the extent of disability.

We are persuaded that claimant had a preexisting psychiatric condition. Therefore, to establish compensability, claimant has the burden of proving that her preexisting condition was worsened by her industrial injury. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Partridge v. SAIF, 57 Or App 163, 167 (1982).

We find that claimant has failed to meet that burden. Although Dr. Carter, the treating psychiatrist, is adamant in his opinion professing a causal relationship, we find the opinions of Dr. Parvaresh and Dr. Radmore just as plausible. Furthermore, we tend to give less weight to Dr. Carter's opinion because he fails to explain his apparent disregard of the factors discussed by his fellow psychiatrists. We consider claimant's psychotic experience, family history of mental breakdowns, substance abuse, preexisting personality makeup and interpersonal relationships worthy of some consideration. At the very least, we feel that these factors should have been addressed by the treating psychiatrist in order to arrive at a complete, well-reasoned opinion. These were significant factors which could conceivably explain her need for treatment. Moreover, claimant was experiencing a number of these problems during the time she sought her current psychiatric treatment. Consequently, we are not persuaded that her compensable condition materially contributed to her current psychiatric condition.

In view of our decision, it is necessary to determine the extent of claimant's permanent disability. The Referee did not discuss the extent issue because he ordered the claim reopened for further psychiatric treatment. On review, the parties have not addressed themselves to this issue. Therefore, we find it appropriate to remand this matter to the Referee for further proceedings, at which time the parties may offer additional evidence concerning the extent of claimant's permanent disability.

ORDER

The Referee's order dated January 20, 1984 is reversed. The insurer's partial denial dated July 12, 1983 is reinstated and affirmed. This case is remanded to the Referee for further proceedings consistent with this order.

MONTE J. McGEE, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-01382
September 28, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's denial of claimant's claim for an industrial injury. SAIF cross-requests review of those portions of the Referee's order which ordered it to pay interim compensation and a penalty and associated attorney's fee. Compensability, interim compensation, the penalty and associated attorney's fee are the issues on review.

The Board affirms and adopts those portions of the Referee's order concerning interim compensation, a penalty and associated attorney's fee.

Claimant is a partner in a framing business. In August 1982 the partnership, which employed one person, obtained workers' compensation insurance from SAIF. Claimant sought treatment for a sore back in August 1982 from Dr. Kiest, but apparently no claim was filed at that time. Dr. Kiest suspected degenerative changes at that time.

Claimant testified that he injured his back while carrying a frame on October 4, 1982. Claimant's testimony was corroborated by the partnership's former employe. Claimant, his partner and the former employe all testified that claimant never thereafter returned to work. However, claimant did not seek medical treatment until November 30, 1982 when he again saw Dr. Kiest. Dr. Kiest suspected a herniated disc.

SAIF denied the claim on January 28, 1983 following an investigation. The Referee upheld SAIF's denial apparently because of "several pieces of this puzzling case that do not fit together." The Referee stated:

> "With these gaps in the puzzle and with claimant not seeking any medical treatment for nearly two months until Dr. Kiest then found a worsening in late November, the chain of causation is all but broken."

The Referee also noted that he was bothered by the alleged problem SAIF had in contacting claimant in order to conduct its investigation. The Referee made no credibility findings based on demeanor.

While claimant's delay in seeking medical treatment may give rise to some questions, it is not, in and of itself, sufficient reason to deny the claim. Neither does it break the chain of causation. Claimant's explanation for the delay is that he thought his problems would resolve and that he did not want the partnership's compensation premiums to go up.

The issue in this case is whether claimant was actually injured on the job as he contends. We find that he was for the following reasons: (1) his injury was witnessed and was corroborated by another employe when the employe was no longer

employed by the partnership; (2) his injury occurred in early October and the job was not finished until November and it was necessary for the partnership to employ somebody else in his place; (3) claimant had previously had back problem but had been able to work in a job demanding long hours, but was unable to work following the incident; (4) Dr. Kiest, who examined the claimant in August and then again on November 30, reported that claimant's back had definitely worsened as a result of the injury. We conclude that claimant suffered an on the job injury as alleged.

As to the reported difficulty in conducting this investigation, it is irrelevant to the issue of whether claimant was actually injured on the job.

ORDER

The Referee's order dated November 30, 1983 is affirmed in part and reversed in part. That portion of the Referee's order concerning interim compensation, a penalty and associated attorney's fee is affirmed. That portion of the Referee's order concerning compensability is reversed. Claimant's attorney is awarded $700 for services at hearing and $500 for services on Board review, to be paid by the SAIF Corporation.

WALTER V. MILLER, Claimant
Malagon, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-09732
September 28, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation requests review of Referee Danner's order which set aside ots partial denial of an aggravation claim and further low back treatments under ORS 656.245.

Claimant sustained a compensable injury on October 5, 1979. The initial medical report describes claimant as suffering from pain in the lower back and right hip. X-rays indicated narrowing of the disc space at the lumbosacral junction. Claimant sought no further treatment until February 1980. At that time claimant had good mobility in his spine but had pain in the lumbosacral and hip areas. During 1980 the right hip became the focus of claimant's medical treatment. Eventually, claimant's right hip joint was surgically replaced.

The prevailing medical opinion concerning the causation of the hip problem was that claimant had an underlying aseptic necrosis which was aggravated by the on the job injury. On January 30, 1981 SAIF sent claimant a denial letter in which it noted that it continued to accept a lumbar strain from the October 5, 1979 injury but denied the hip problem. The denial was set aside by a Referee in July 1981. In June 1981, shortly before the hearing on the denial, Dr. Degge examined claimant. In his report he opined:

> "It would then appear to be a situation where there is a true aggravation of a pre-existing pathological process [the aseptic necrosis of the hip]. His back complaints, which he tends to minimize today, are possibly on the basis of osteoarthritic changes in the lower lumbar area and have long since run their course."

On November 20, 1981 a Determination Order granted claimant an award for a 35% scheduled disability to the right leg. In December 1981 claimant fell and injured his right knee. The knee injury was accepted as a sequela of claimant's hip injury. A Determination Order granted claimant a scheduled award for 20% loss of the right leg due to the knee injury. In September 1982 Dr. Woolpert, claimant's treating physician, noted that claimant was experiencing problems with his balance. He noted that the balance problem might be related to excessive consumption of alcohol.

In August 1983 claimant was diagnosed as having marked cervical spondylosis with secondary myelopathy. The parties agree that the cervical spondylosis is not related to claimant's compensable injury. On August 12, 1983 Dr. Hockey performed a cervical laminectomy. While claimant was in the hospital recovering from the cervical laminectomy, he fell and immediately experienced low back pain. No physician opines that the fall was caused by a compensable condition, however, Dr. Woolpert opined:

> "The patient has had a longstanding problem in respect to his back, dating back to the original injury and although it has not been recorded or reported to any great extent, he has had some continued complaints in respect to his back. His primary problem of course, has been his hip and knee. However, he has continued to complain of his back and I would feel his present problem is an aggravation of his underlying problem and therefore I am requesting time loss in respect to his low back problem."

SAIF denied an aggravation claim and further medical treatment for the low back condition on October 3, 1983. On January 19, 1984 Dr. Degge examined claimant and reported:

> "This workman appears to have sustained a strain of the lumbar spine and an osteochondral fracture, secondary to aseptic necrosis of the right hip as a result of the accident of October 5, 1979. He subsequently sustained a fracture of the right patella, due to instability from either alcoholism or advancing spastic paralysis of his lower extremities, causing the right leg to give way and resulting in the fracture. A strain injury related to the lumbar spine appears to have run its course and resolved. Ongoing complaints appear to this examiner to be on the basis of a non-work related degenerative change, i.e., spondylosis at L2-L3 and L5-S1 associated with degenerative changes in the apophyseal joints."

Dr. Woolpert responded that he was basically in agreement with Dr. Degge except that:

"If I accept the patient's history of having discomfort from the back from his injury on, I would have to feel that the patient does have at least some residual back difficulty from the injury which I would feel would rate a minimal rating."

The Referee relied on Dr. Woolpert's opinion and overturned SAIF's denial. We disagree. Despite the fact that Dr. Woolpert is claimant's treating physician, we find Dr. Degge's opinion more persuasive. The injury to claimant's low back in October 1979 was apparently not a major injury. While he complained of low back pain initially, there are only fleeting references to low back problems from 1979 through 1983. As early as June 1981 when Dr. Degge first examined claimant, he noted that claimant minimized any back problems. At that time, Dr. Degge opined that the original strain had resolved. Dr. Degge's opinion that claimant's low back problems are caused by underlying degenerative changes rather than a four year old strain seems logical to us.

Dr. Woolpert's statement that claimant had some back problems during the intervening years is not sufficient to establish to our satisfaction that the original injury, rather than a degenerative process, was the cause of those complaints. It is certainly insufficient to convince us that the original strain is a material cause of back problems four years later.

In order to sustain his burden of proof, claimant must prove by a preponderance of the evidence that his original injury is a material cause of his current low back condition. Grable v. Weyerhaeuser Company, 291 Or 387 (1981). Claimant has failed to sustain his burden.

ORDER

The Referee's order dated March 28, 1984 is reversed. The SAIF Corporation's denial dated October 3, 1983 is reinstated.

TERESE L. PANECALDO, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 83-03853
September 28, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The self-insured employer requests review of Referee Brown's order which set aside its denial of claimant's mental stress claim. The issue is the compensability of claimant's emotional decompensation in the spring of 1983. We find that claimant has failed to establish that her mental stress arose out of and in the scope of her employment with Jackson County; therefore, we reverse.

We agree with the Referee's findings of fact and adopt them as our own. Based thereon, however, we draw some different legal conclusions, which lead us to a contrary result.

There is no issue concerning medical causation. All physicians are essentially in agreement that there appear to be no significant nonvocational psychosocial stressors which contributed to claimant's emotional decompensation in the spring of 1983.

Although Dr. Colbach expressed a certain sense of bewilderment and frustration at not having a better understanding of the nonvocational contemporaneous events in claimant's life, he agreed that the events of claimant's employment were the major contributing cause of her breakdown.

Rather, resolution of this case turns on a determination of whether claimant has satisfied her burden of proving legal causation. In this regard, the following statement from Dr. Holland's comprehensive August 1, 1983 report is elucidating:

> "Psychiatric diagnosis simply does not have the precision to attribute specific events as contributing a major causal factor. This person obviously is responding to the circumstances unfolding in her employment in such a way as to be characterized as an emotional disturbance. I can find no evidence of events in her life elsewhere which would be productive of this emotional disturbance. Whether or not this emotional disturbance results from supervision of activities within or beyond the normal course of employment is impossible to sort out psychiatrically."

Dr. Colbach, however, was able to identify seven instances of supervisory pressure which, in his opinion, cumulatively caused claimant's symptoms. As found by the Referee, Dr. Colbach grouped those seven instances into three separate areas of employment stressors. First, the events surrounding claimant's 1981 sick leave, consequent suspension from employment and subsequent reinstatement, and perceived change in supervisory attitudes toward claimant. Second, claimant's reprimand for abuse of telephone privileges, consequent repercussions suffered by claimant's co-workers as a result of her transgressions, and the "loss of love" (to use Dr. Colbach's terminology) felt toward claimant and expressed directly to her by her co-workers. Third and finally, the series of events concerning claimant's personal relationship with Tina Lewis, one of her co-workers. Dr. Colbach opined that the combination of any two of these three employment stressors would constitute the major contributing cause of claimant's decompensation.

The Referee concluded that the series of events surrounding claimant's relationship with Tina Lewis were purely personal, and although the claimant experienced stress at work as a result of this series of events, this portion of her stress did not arise out of her employment. Therefore, he concluded that this stressor, which remained purely personal to claimant, did not arise out of and in the scope of claimant's employment and, therefore, could not be considered in the legal cause computation. We are in complete agreement with this portion of the Referee's analysis and affirm and adopt the relevant portions of his order. See Robinson v. Felts, 23 Or App 126 (1975); Blair v. SIAC, 133 Or 450, 455 (1930); Oliver S. Brown, 35 Van Natta 1646 (1983); Kenneth Hollin, 27 Van Natta 837 (1979).

The Referee thoroughly considered the evidence concerning the 1981 sick leave incident, and he concluded, contrary to the

employer's assertions, that the confusion surrounding that episode was more in the nature of "inadvertent misunderstanding as opposed to premeditated deception," as stated by claimant's physician at that time, Dr. Narus. The source of claimant's emotional stress relative to the circumstances surrounding this 1981 sick leave incident involve a perception on claimant's part that, because she prevailed in her grievance against the employer and her suspension was withdrawn, there was a subsequent change in supervisory attitude and treatment. The Referee found, and we agree, "The record, however, does not support her perception she was unduly denied vacation and comp time requests. Her evaluations were also relatively benign during the interim period." In addition, testimony from other witnesses tends to establish that there was, in fact, no change in supervisory treatment toward claimant. The Referee concluded that, although claimant's perceptions of supervisory harrassment were not accurate, they were not feigned, and they had their origin "in the first instance in the work place." Based upon the state of the law of mental stress claims at the time the Referee's order was issued, he was correct to conclude that claimant had sustained her burden of proving that the emotional stress which derived from this sick leave incident was appropriately considered a factor in the legal cause formula. The state of the law at that time was embodied in the Court of Appeals' McGarrah v. SAIF, 59 Or App 488 (1982), which, as noted by the Referee, "seemingly left very little with which an employer [could] defend a stress claim arising out of supervisory contact."

Since the date of the Referee's order, the Supreme Court has considered the standard for establishing legal causation in employment-related mental stress claims. In discussing the Court of Appeals' purely subjective standard, the Supreme Court stated, in part:

> "This standard is no standard at all in the reality of application. In cases where the disability or impairment is established, the subjective test for causal nexus would result in an award of compensation for virtually all, if not all, claims based on mental disorders. If the claimant perceived that the job conditions caused the mental disorders, even if this were not true, the employer would be liable. The subjective formulation ignores the fundamental statutory requirement that diseases or disorders arise out of and in the scope of employment. An honest perception of that which does not factually exist is an insufficient causal nexus for an occupational disease claim.
>
> "The stressful conditions must actually exist on the job. That is, they must be real, not imaginary. The views of an average worker or average person or the perceptions by the claimant may be relevant, but are not determinative. The existence of legal cause of stress-related occupational disease must be determined objectively." 296 Or 145, 165 (1983).

The historical events which led to claimant's emotional stress relative to the 1981 sick leave episode did, in fact, occur. However, it is not these events -- the suspension, the following grievance and the eventual reinstatement -- which caused claimant emotional stress. Rather, the supposed events which caused claimant emotional stress -- the change in supervisory attitude and treatment -- actually did not occur. Since this supervisory change in attitude and treatment was merely a perception on claimant's part, under the objective standard enunciated by the Supreme Court, this employment stressor cannot be considered in the legal cause formula. See also Elwood v. SAIF, 67 Or App 134 (1984).

Thus, two of the three possible groups of employment stressors are eliminated from the legal cause formula. It would not be necessary, therefore, to analyze this case further for purposes of our disposition of claimant's mental stress claim; however, we recognize the possibility, if not the likelihood, that this case will be reviewed by higher authority, and for that reason, we deem it appropriate to state our conclusions concerning the third and remaining group of employment stressors, i.e. the stress related to the series of events which arose out of claimant's excessive personal use of the employer's telephone lines.

Claimant had a habit of using the telephone lines for personal phone calls while she was on duty at the board. She had been advised by her supervisors that she engaged in these personal phone calls to excess. Eventually, in December of 1982, she received an oral warning regarding extensive -- both in number and duration -- personal telephone calls while on duty. In the latter half of January 1983 she was given a written reprimand regarding phone calls while on duty. As the Referee found, a finding with which we agree, claimant's reprimands were not, in and of themselves, the cause of her emotional stress. Rather, as a result of claimant's excesses, the employer removed the single untaped telephone from the lunch room, as a result of which claimant fell victim to castigation by her co-workers, i.e. suffered the "loss of love" of her peers. Because claimant was informed of the hard feelings that her co-workers harbored for her during the course of a meeting called by the supervisors, the Referee concluded that the "phone stressor" was not merely "at work," but that it became "of work," and, therefore, constituted a legal cause of claimant's stress. We disagree with this analysis.

The employer argues that claimant's extensive personal use of the telephones was clearly prohibited, and, therefore, such use of the telephones constituted an activity outside the scope of claimant's employment. Any consequences flowing from this prohibited activity, therefore, cannot be considered in the legal cause formula because, according to the employer, such consequences do not arise out of and in the scope of claimant's employment. We agree.

In Dallas C. Poage, 35 Van Natta 1318 (1983), aff'd without opinion 68 Or App 454 (1984), we discussed, although in dicta, the same concept advanced by the employer in this case. The claimant in Poage was a police sergeant who suffered mental stress as a result of disciplinary action initiated by the employer. The reason for the disciplinary action was that the claimant had

kicked an arrested, handcuffed person in the head. The case was argued and decided on the major causation issue, i.e. whether the conditions of claimant's employment were the major contributing cause of his emotional stress; however, before addressing that issue, we stated:

> "It is clear that injuries sustained while engaged in activity that an employer has prohibited are not compensable. For example, in Frosty v. SAIF, 24 Or App 851 (1976), claimant was a charter bus driver who took a group skiing, went skiing himself despite instructions from his employer not to do so, and was injured while skiing; the court concluded that claimant's injuries did not arise within the scope of his employment. In [McGarrah v. SAIF, supra], the [Court of Appeals] mentioned a hypothetical based on the Frosty facts:
>
> > 'A better test of the Board's rule, on its face, might be presented if the claimant in Frosty had suffered a psychological disability as a direct result of his supervisor having castigated him severely for having skiied while on a charter run, contrary to expressed instructions, even though he performed well the job for which he was hired.' 59 Or App at 454.
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> * * *
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> "We think the facts of this case present exactly the same question as the hypothetical drawn from Frosty. This claimant has been subjected to employer discipline for having assaulted a prisoner in his custody contrary to express instructions. It is quite clear that a claim for physical disability sustained while assaulting a prisoner would not be compensable, as illustrated by Wayne Patterson, 34 Van Natta 1493 (1982):
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> > 'Claimant . . . grossly deviated from what he had to understand to be his job duties by physically attacking a person in his custody and to whom he had at least some duty of care. In short, claimant's injury was sustained . . . while doing something he had no right to do in connection with his employment or anything else.'
>
> "How then can employer disciplinary action for engaging in exactly the same prohibited

> activity possibly lead to a compensable claim for psychological disability? The Court of Appeals' decision in McGarrah does not answer that question; indeed, it expressly leaves that question unanswered. * * * *" 35 Van Natta at 1318-19.

Neither does the Supreme Court's decision in McGarrah, which focused primarily on the subjective versus objective standard, answer the question raised herein. Some guidance is offered, however, by the Court of Appeals decision on review of our order in Wayne Patterson, supra. Patterson v. SAIF, 64 Or App 652 (1983).

The claimant in Patterson was a security guard at the University of Oregon Health Sciences Center. Part of his job was to assist in the management of unruly patients. He was called to the psychiatric crisis center to assist the medical staff in releasing a patient who did not want to leave the unit. The medical staff wanted the patient taken "off the hill," meaning that he was to be taken to the edge of the employer's premises and released. While claimant and another security guard were escorting the patient out of the crisis unit, he became unruly. The patient was restrained and handcuffed. The employer's policy in such situations, which had previously been specifically communicated to claimant, was that such persons were only to be transported to the edge of the hospital grounds and released. Notwithstanding these instructions, claimant and the other security guard placed the patient in the employer's patrol car and drove to downtown Portland to release him. When the three arrived in downtown Portland, the patient was removed from the patrol car, at which point he became verbally abusive and began to walk away, still wearing the pair of handcuffs. The other security guard stopped the patient by grabbing the handcuffs and led him back to the patrol car. Claimant then forcibly and repeatedly kicked the patient, forcing him into the back seat of the patrol car. In the course of that attack on the patient, claimant injured his back. 64 Or App at 654; 34 Van Natta at 1493.

We concluded in Patterson that claimant deviated from his employer's instructions by transporting the patient to downtown Portland, rather than just to the edge of the employer's premises. We also concluded that claimant "grossly deviated" from his job duties by physically attacking the patient. On review by the Court of Appeals, SAIF conceded that the dispositive misconduct was the prohibited act of leaving the premises, as opposed to assaulting the patient. The court found and held:

> "Bearing in mind that the purpose of the Workers' Compensation Act is financial protection of an injured worker without regard to fault, we conclude that claimant's injury is sufficiently work-related to be compensable. [See Rogers v. SAIF, 289 Or 633 (1980).] He was injured while he was executing the assigned task of removing an unruly patient from the employer's premises. His disregard of the employer's rules was deliberate but did not involve a prohibited overstepping of the boundaries defining his job

> responsibilities. Rather, his misconduct involved a violation of the employer's rules governing the method of accomplishing his ultimate work, and therefore he remained within the scope of his employment. See 1A Larson, Workmen's Compensation Law 6-7, §31.00 (1979)."
>
> "* * * [C]laimant's misconduct is nothing more than disobedience to specific instructions limiting the sphere of the execution of his employment responsibilities. Because we find that misconduct to be a mere violation of the designated method of execution of his ultimate job duty, the resulting injury is sufficiently work-related to be compensable." 64 Or App at 656. (Emphasis in original.)

The "injury-producing activity" in this case is claimant's excessive personal use of the employer's emergency telephone lines. Claimant had been advised of her excesses in this regard during previous performance appraisals; she had been given oral warning concerning her excesses; and finally she was given a written reprimand. There can be little doubt that this was a prohibited activity which, in and of itself, was outside the scope of claimant's employment. Her misconduct involved a violation of the employer's rules governing an activity which was personal in nature and, at best, incidental to her employment activity. Unlike the claimant in Patterson, claimant's misconduct did not involve a violation of the employer's rules concerning the "method of accomplishing the ultimate work" task. For this reason, the injury-producing activity is significantly and decidedly different from the injury-producing activity in Patterson.

The fact remains, however, that the employer's disciplinary action in response to claimant's excessive personal use of the telephone lines was not, in and of itself, the direct cause of claimant's mental stress. Rather, claimant's emotional distress originated from her confrontation with the other telephone operators, who informed claimant of their feelings toward her, which were, in turn, the result of supervisory action taken in response to claimant's misconduct. The fact that claimant's supervisors called a meeting during the course of which claimant's co-workers expressed their feelings toward her, is less significant, in our mind, than the fact that claimant's co-workers were disturbed as a result of her prohibited conduct and the consequences thereof. This peer group criticism existed as a result of claimant's prohibited personal activities. Under these circumstances, we do not believe that claimant's reaction to her co-workers' criticism, i.e. her resulting mental stress, is sufficiently related to her employment to be considered compensable. Rogers v. SAIF, supra.

In sum, we find and hold that none of the three major groups of employment stressors identified by Dr. Colbach arose out of and in the scope of claimant's employment with Jackson County. The "Tina Lewis" stressors were primarily personal in nature and insufficiently work-related to result in compensable mental stress; the change in supervisory treatment and attitude which

allegedly followed the 1981 sick leave incident was merely perceived by claimant and did not exist in reality; and the mental stress experienced by claimant in association with the employees' loss of the lunch room telephone was a consequence of claimant's own misconduct, which had nothing to do with the execution of her ultimate job duties. Accordingly, claimant's mental stress claim is not compensable, and the employer's denial must be reinstated.

ORDER

The Referee's orders dated October 7, 1983 and November 2, 1983 are reversed, and the employer's denial dated April 13, 1983 is reinstated and affirmed.

STEPHAN L. RENNELLS, Claimant
Robert L. Chapman, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-05548 & 83-03723
September 28, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Mongrain's order which awarded claimant's counsel a $1,500 attorney fee for setting aside SAIF's denial of a medical-only claim. On review, SAIF contends the fee is excessive. We agree and modify the Referee's order.

Claimant is a 47-year-old electrician for SAIF's insured. In June 1981 he experienced low back pain while assisting a coworker move a piece of heavy equipment. Claimant sought medical treatment approximately 10 days later, but had his private insurer billed. He did not file a workers' compensation claim at that time. Claimant testified that he mentioned the incident to his supervisor. The parties stipulated that the supervisor would testify that he did not recall claimant's report of the incident.

In January 1982 claimant experienced low back discomfort while at work. Although he sought medical treatment, he did not miss any time from work. Claimant filed a claim on February 2, 1982, alleging a January 28, 1982 injury. SAIF accepted the claim as a nondisabling injury on February 25, 1982. Subsequently, SAIF received a report from Dr. Weinman, claimant's treating orthopedist, which diagnosed a mildly herniated disc and indicated that claimant had sustained an injury in June 1981. Based on the new information, SAIF denied the claim on April 7, 1982.

In a January 1983 deposition, Dr. Weinman testified that claimant probably experienced a small tear in the outer part of his disc in June 1981 which was merely aggravated by the January 1982 injury.

On March 24, 1983 claimant filed a claim concerning the June 1981 injury. The next day, in a letter to SAIF's counsel, claimant's counsel requested that the employer's safety and personnel director, Mr. Smith, submit to a deposition and produce claimant's personnel file. Claimant's counsel suggested that the deposition take place at the Medford Workers' Compensation Board office to insure that a Referee would be available to rule whether certain documents contained in the file were discoverable. By letter dated April 1, 1982, SAIF's counsel stated that he was instructing Mr. Smith to bring only documents dated after January 28, 1982 (the date of injury for the February 1982 claim). SAIF's counsel further advised that he would be more

comfortable with claimant's request for production of the personnel file if claimant would wait until his June 1981 injury claim had been fully processed and a request for hearing had been filed.

On April 15, 1983 SAIF denied the June 1981 injury claim based on insufficient evidence and untimely reporting. SAIF further noted that claimant refused to be interviewed. By letter dated April 19, 1983 claimant's counsel requested that the Referee order SAIF to be held responsible for the costs of deposition of Mr. Smith, since Mr. Smith refused to be deposed non-stenographically.

Both claims were litigated at hearing, at which time Mr. Smith testified. The Referee upheld the denial of the June 1981 injury claim, finding that the claim was untimely filed and that the record established prejudice to the employer. The Referee set aside the denial of the January 1982 injury claim, finding that SAIF was precluded from denying the entire claim under Bauman v. SAIF, 295 Or 788 (1983). Claimant's counsel was awarded $1500 for services in setting aside the denial.

Attorney fee awards are based on efforts expended and results obtained. OAR 438-47-010(2). Generally, "results obtained" in the form of additional medical services are considered to be rather modest. Derry D. Blouin, 35 Van Natta 570 (1983). Here, claimant obtained his aggravation rights on his January 1982 medical only claim. Claimant received no compensation because his medical bills had been paid by his private carrier and he had missed no time from work. We sympathize with claimant's contention that based on SAIF's posture, additional time and expense were required as the two claims became increasingly interrelated. However, considering the confusing nature of the June 1981 injury claim and the evolution of the causal relationship issue, we find SAIF's actions understandable.

Applying the standards of OAR 438-47-010(2), we find that an attorney's fee of $750 would be more appropriate.

ORDER

The Referee's order dated January 13, 1984 is modified. That portion of the order which awarded claimant's attorney a separate fee is modified. Claimant's attorney shall receive $750 for setting aside the SAIF Corporation's denial of April 7, 1982.

JOSEPH A. REZNICSEK, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-06733
September 28, 1984
Order on Review

Reviewed by Board Members Barnes and Ferris.

The SAIF Corporation requests review of Referee Braverman's order which required it to pay claimant's temporary total disability benefits based on claimant's rate of pay in 1983 rather than his rate of pay in 1945. Despite references to the contrary, this case has nothing to do with the law in effect in 1945 versus the law in effect in 1983. Rather, the question is whether the amount of benefits claimant is to be paid in connection with this accepted occupational disease claim should be based on the factual

circumstances that existed in 1945 or the factual circumstances that existed in 1983.

This claim is based on claimant's exposure to asbestos. Claimant's last exposure to asbestos was in 1945; indeed, this is a claim against claimant's pre-1945 employer. As is typical of asbestos-related disease, there was a long latency period before the disease first appeared in 1983.

When SAIF accepted the claim, the present dispute arose concerning at what rate the compensation for temporary total disability should be paid. If this were an injury claim, the answer would be simple. Basically, temporary total disability benefits are calculated as a percentage of a worker's wages on the day of injury. ORS 656.210(1), 656.202(2), 656.005(27). To illustrate, if a worker sustained a compensable traumatic injury on the last day of the month, it would be irrelevant if the worker were previously scheduled to get a pay increase (or a pay decrease) on the first of the next month; instead, the percentage-of-wages component of the worker's time loss benefits would be based solely on wages on the date of the injury.

That simplicity breaks down in the context of an occupational disease claim. The legislature has provided that disease claims should be processed the same as injury claims, ORS 656.807(5), but has not said how to determine "date of injury" for purposes of calculating the amount of benefits to be paid in connection with a compensable disease claim. As a result, the workers' compensation system has developed a fiction called "assigned injury date" which is used as part of the calculus of benefits in occupational disease claims. The ultimate question in this case is whether claimant's mesothelioma claim should be processed with an assigned injury date of 1945 or an assigned injury date of 1983.

We are aware of no appellate court or Board decisions that discuss the concept of "assigned injury date" in a way that is helpful for present purposes. However, reasoning by analogy, we conclude that the available precedents more strongly suggest that this claim should be processed with an assigned injury date of 1945, when claimant was last exposed to asbestos.

United Pac. Reliance Inc. v. Banks, 64 Or App 644 (1983) involved an insurer responsibility issue that arose on the following facts: Claimant sustained a shoulder injury while working in January, but continued working with pain and did not seek medical attention; the employer changed insurers in March or April; claimant first sought medical treatment in May, and her doctor took her off work at that time. In sum, the injury happened while one insurer was on the risk, but there was no resulting disability until another insurer was on the risk. The court concluded:

> "We agree with the Board that the insurer covering the risk at the time of the injury bears responsibility for that injury, even if resulting disability develops later. That is the arrangement contemplated by the compensation statutes."

In other words, in an injury context, the date of injury, rather than the date of subsequent disability following a latency period, fixes insurer responsibility. By analogy, the same event

that fixes insurer responsibility should also fix the amount of a claimant's benefits that are based on wages. To illustrate, if the claimant in Banks had received a pay increase (or decrease) between the injury in January and the resulting disability in May, would that claimant's benefits that are computed as a percentage of wages be based on January wages or May wages? We understand ORS 656.210(1) to clearly provide that such benefits would be based on January wages, and the fact that there was a latency period and subsequent disability would be irrelevant.

In a disease context, it is the date of last injurious exposure that fixes insurer responsibility. Likewise, just as in an injury context, that same event should fix the amount of benefits that are based on wages, and latency periods and subsequent disability should be irrelevant.

This scheme makes sense because an insurer's potential liability (and thus an insurer's charges for the services it provides) are necessarily based in part on the employer's payroll at the time it provides coverage. This is illustrated by Reed v. SAIF, 63 Or App 1 (1983). In Reed, the claimant had a full-time job and "moonlighted" at a concurrent part-time job; the claimant became totally disabled as a result of an injury at the part-time job; and the question arose of whether the claimant's benefits should be based only on his wages at the part-time job or, instead, on his total wages from both jobs. In holding that the benefits should be based on income from the part-time employment, the Court of Appeals noted "a fundamental policy of the compensation system that employers should bear directly or through insurance the cost of injuries to their employes incurred in their service," 63 Or App at 4, and concluded: "This [part-time] employer was required only to protect this employe against risk of industrial injury incurred in its employ, and that is all the insurance it was required to buy or that SAIF was required to sell." 63 Or App at 4.

Those comments about injuries incurred in employment are equally applicable to diseases caused by employment. SAIF was providing insurance to claimant's pre-1945 employer based on the employer's payroll at that time. Forty years of subsequent inflation have since increased claimant's wages about 15-fold, but we do not believe that is a risk that SAIF or this employer were insuring against pre-1945.

If claimant's arguments were correct, two workers who received identical exposures from the same employer at the same time and became symptomatic with mesothelemia at the same time could end up receiving from SAIF very different TTD rates depending on the subsequent work history. For example under claimant's theory, a claimant who worked in the shipyards in 1945 but thereafter returned home and worked as a housewife without receiving any more wages would be entitled only to TTD based on the 1945 wage rate because there would be no wage rate in 1983, the time the disability arose, upon which to base the rate of TTD. On the other hand, a claimant who was exposed to asbestos in 1945 but continued to work until 1983 when the disease became apparent would be entitled to TTD based on the wage rate in 1983. We do not believe that such an anomalous result was intended by the legislature.

For all of these reasons, we conclude that SAIF need only pay claimant, from its own resources, benefits based on a 1945 assigned injury date. It does not follow, however, that claimant will only receive token benefits. The legislature has anticipated this problem, at least in general terms, and has created the Retroactive Reserve to address it. "The purpose of the Retroactive Reserve is to provide increased benefits to claimants . . . which are lower than currently being paid for like injuries." ORS 656.636(2)(b). Under this scheme, SAIF is responsible from its own resources for some of claimant's benefits -- those based on his 1945 wages, and the Retroactive Reserve will pay an additional amount of benefits. From claimant's point of view the net effect as far as benefits received is about the same as ordering that this claim be processed under a 1983 assigned injury date. From SAIF's point of view, the difference is substantial; SAIF is only responsible for providing benefits based on a loss that it actually insured in 1945; and the Retroactive Reserve, which is funded by every working person in Oregon, ORS 656.637, will provide benefits for a loss that realistically could not even have been insured against because the risk was unknown 40 years ago.

ORDER

The Referee's order dated November 15, 1983 is reversed. The claim is remanded to the SAIF Corporation for processing consistent with this order.

ROBERT SMELTZER, Claimant
Doblie & McSwain, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-08160
September 28, 1984
Order on Review

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Knapp's order which upheld the SAIF Corporation's denial of claimant's industrial injury claim, granted an attorney's fee out of interim compensation awarded rather than a carrier paid fee and declined to assess a penalty against SAIF for failing to accept or deny within fourteen days of claimant's claim.

The Board affirms and adopts those portions of the Referee's order concerning compensability.

On the issue of attorney's fees and penalty, we reverse. SAIF did not accept or deny until twenty four days after claimant filed his claim. The Referee correctly ordered SAIF to pay interim compensation for that period. However, he did not assess a penalty against SAIF and he ordered an attorney's fee paid out of the compensation awarded rather than a carrier paid fee. Failure to accept or deny within fourteen days and failure to pay interim compensation pending acceptance or denial constitutes unreasonable resistance to the payment of compensation. ORS 656.382(1) provides that where the insurer unreasonably resists the payment of compensation the "insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney's fee." SAIF had an obligation to accept or deny or begin paying interim compensation within fourteen days. It did not do so until twenty four days had elapsed. Such a delay is sufficient to warrant a

penalty. SAIF is assessed a penalty of 15% of the interim compensation payable under the Referee's order.

In addition, because we are assessing a penalty against SAIF for failure to pay interim compensation pending acceptance or denial, we assess an associated attorney's fee payable by SAIF rather than the attorney's fee payable out of the increased compensation as ordered by the Referee.

ORDER

The Referee's order dated March 1, 1984 is affirmed in part, modified in part and reversed in part. That portion of the Referee's order concerning compensability is affirmed. That portion of the Referee's order which fails to assess a penalty against SAIF is reversed. SAIF is ordered to pay claimant a penalty of 15% of the increased compensation payable under the Referee's order. That portion of the Referee's order allowing attorney's fees out of increased compensation is modified; the SAIF Corporation is ordered to pay claimant an attorney's fee of $300 for prevailing on the issue of unreasonable resistance to the payment of compensation. Claimant's attorney is awarded $200 for services on Board review, to be paid by the SAIF Corporation.

BOARD MEMBER BARNES, dissenting:

I dissent, more from what the majority does not say, although what the majority does say has its strange elements too.

Claimant's attorney argues on review that the Referee should have ordered an attorney fee paid in addition to claimant's increased compensation rather than out of claimant's increased compensation. To explain what this means in concrete terms, assuming that the additional temporary disability benefits ordered by the Referee would be $1,000:

(1) Under the terms of the Referee's order, claimant has received $750 and claimant's attorney has received $250 (as discussed below, the Board has ruled that this type of attorney fee has to be paid pending review); and

(2) As I understand it, claimant's attorney's argument on review is that his client should receive $1,000, and his attorney fee should be insurer-paid in addition to his client's increased compensation.

The majority fails to say whether claimant should receive all of the $1,000. The majority only states:

> "That portion of the Referee's order allowing attorney's fees out of increased compensation is modified; the SAIF Corporation is ordered to pay claimant an attorney's fee of $300 . . ."

Does this mean claimant's attorney keeps the $250 he has already been paid out of claimant's increased compensation, and now gets $300 more?

I assume so because: (1) the majority does not say that the Referee did anything wrong in allowing claimant's attorney a fee

of 25% of claimant's increased compensation; and (2) even if the majority thinks (but is not willing to say) that claimant's attorney's fee should have been entirely insurer-paid, in Robert G. Perkins, 36 Van Natta 1050 (1984), my Board colleagues ruled that attorney fees allowed from increased compensation must be paid pending Board review, and a claimant's attorney is entitled to retain any fees paid pending review that, based on the decision on review, were erroneously paid.

The facts in this case reinforce my belief that Perkins was wrongly decided. Payment of attorney fees pending review necessarily creates a glaring conflict of interest between an attorney and a client in any case in which there is an issue of whether attorney fees should have been allowed out of increased compensation or awarded in addition to compensation. This type of case comes down to: Should the client receive 100% of the compensation awarded by the Referee even though part of it has already been paid to the attorney who, under Perkins, has the right to retain what he has received? Whose interests do we really expect an attorney to represent in such a dispute?

We would not create this kind of ethical dilemma if, as I suggested in my dissent in Perkins, attorney fees allowed by a Referee were held in some status like escrow pending the ultimate appellate outcome.

GARY O. SODERSTROM, Claimant
FRED & SONJA SHEWEY (dba FRED'S PLACE)
Garry L. Kahn, Attorney
Macdonald, et al., Attorneys
Carl M. Davis, Asst. Attorney General

WCB 81-05426
September 28, 1984
Order on Reconsideration

The putative noncomplying employer has requested Board review of Referee Mulder's order upholding an order of the Workers' Compensation Department which found that the employer was a noncomplying employer. We issued an Order of Dismissal on the ground that under ORS 656.740(4) we lacked jurisdiction. Upon discovering that we had relied on the 1983 version of ORS 656.740(4) rather than the version in effect at the time review was requested, we abated our Order of Dismissal. The issue on reconsideration is whether, under the law in effect at the time review was requested, the Board or the Court of Appeals was the proper route of appeal from the Referee's order.

Claimant was injured on June 4, 1980 while allegedly working for the putative noncomplying employer. On May 26, 1981 the Compliance Division of the Workers' Compensation Department issued an order declaring the putative noncomplying employer to be a noncomplying employer. The employer requested a hearing. We found in our earlier order and continue to find that the only issue before the Referee was whether the putative noncomplying employer was, in fact, a noncomplying employer. Accordingly, we found and continue to find that the hearing raised no issues concerning a claim. At hearing, the Referee upheld the Department's order. The employer then requested Board review.

In our original order we relied on the 1983 version of ORS 656.740(4) which states that in cases in which the issue is the noncomplying status of a party, review is to the Court of Appeals under the Administrative Procedures Act unless the case also

involves questions concerning a claim. However, at the time review was requested the 1983 version of ORS 656.740 was not yet in effect. The version in effect at the time review was requested stated:

> "(1) A person may contest a proposed order of the director declaring that person to be a noncomplying employer, or a proposed assessment of civil penalty, by filing with the department, within 20 days of receipt of notice thereof, a written request for a hearing. Such a request need not be in any particular form, but shall specify the grounds upon which the person contests the proposed order or assessment. An order by the director under this subsection is prima facie correct and the burden is upon the employer to prove that the order is incorrect.
>
> (2) * * *
>
> (3) A hearing relating to a proposed order declaring a person to be a noncomplying employer, or to a proposed assessment of civil penalty under ORS 656.735, shall be held by a referee of the board's Hearings Division; but a hearing shall not be granted unless a request for hearing is filed within the period specified in subsection (1) of this section, and if a request for hearing is not so filed, the order or penalty, or both, as proposed shall be a final order of the department and shall not be subject to review by any agency or court.
>
> (4) Notwithstanding ORS 183.315(1), the issuance of orders assessing civil penalties pursuant to this chapter, the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:
>
> (a) The order of a referee in a contested case shall be deemed to be a final order of the board.
>
> (b) The director shall have the same right to judicial review of the order of a referee as any person who is adversely affected or aggrieved by such a final order."

We now attempt to discern the extent of our jurisdiction prior to the 1983 amendments.

In 1981 the Court of Appeals decided SAIF v. Broadway Cab Co., 52 Or App 689 (1981). In Broadway Cab, the issue was whether the Hearings Division or the Board had subject matter jurisdiction to decide an issue between SAIF and the employer over whether owner-drivers were subject workers. At that time, ORS 656.704 stated:

"(1) Where ORS 656.001 to 656.794 does not provide a procedure for administrative or judicial review of actions and orders of the department or State Accident Insurance Fund Corporation, the provisions of ORS 183.310 to 183.500 shall apply to the board review and judicial review of such actions and orders.

"(2) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining the procedure for the conduct and review thereof, matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof are directly in issue. However, such matters do not include any proceeding under ORS 656.248 or any proceeding resulting therefrom."

The court noted that under the 1979 version of ORS 656.704 the only grant of subject matter jurisdiction in the Hearings Division or in the Board was in matters concerning a claim. The court noted, however, that under ORS 656.708(3) the Hearings Division had authority to conduct "such other hearings and proceedings as may be prescribed by law." It also noted that under ORS 656.726(2) the Board may provide "such other review functions as may be prescribed by law." The court pointed out two examples of matters "prescribed by law" which seemed to be outside the general jurisdictional grant in ORS 656.704. These included noncomplying employer cases under ORS 656.740 and cases involving penalties and assessments under ORS 656.745(3). The court questioned but did not decide whether the Department could, by rule, invest the Hearings Division with jurisdiction to hear other types of cases.

The 1981 legislature subsequently amended ORS 656.704 by adding the current subsection "2" which states:

"(2) Actions and orders of the director and the conduct of hearings and other proceedings pursuant to ORS 656.001 to 656.794, and judicial review thereof, regarding all matters other than those concerning a claim under ORS 656.001 to 656.794 are subject only to ORS 183.310 to 183.550 and such procedural rules as the director may prescribe. The director may make arrangements with the board pursuant to ORS 656.726(7) to obtain the services of referees to conduct such proceedings or may make other arrangements pursuant to ORS 656.726(7) to obtain the services of referees to conduct such proceedings or may make other assignment pursuant to ORS 656.722 to obtain personnel to conduct such proceedings. The director by rule shall

> prescribe the classes of orders issued by referees and other personnel that are final, appealable orders and those orders that are preliminary orders subject to revision by the director."

The old subsection "2" was retained and renumbered as subsection "3". Thus, the 1981 amendment to ORS 656.704 specifically puts review of Department decisions in matters not concerning a claim in the APA appeal route, but also allows the Department to use Referees from the Hearings Division to hear such cases. ORS 656.740 remained unchanged from the time Broadway Cab was decided until the 1983 amendments.

In summary, at the time review was requested, ORS 656.704 divided jurisdiction between the Department and the Board along the lines of matters concerning a claim. The Department had jurisdiction over matters not concerning a claim and review of decisions on such matters was through the APA. However, Referees from the Hearings Division had authority to hear such cases. At the time review was requested ORS 656.740 specifically allowed a putative noncomplying employer to obtain a hearing before a Hearings Division Referee to protest a Department finding of noncomplying employer status. The statute also allowed a similar hearing in cases involving civil penalties under ORS 656.735. The statute provided that in civil penalties cases, review of the Referee's decision was via the APA route to the Court of Appeals. It did not mention review of noncomplying employer cases.

Thus, at the time review was requested in this case, the Hearings Division had authority under two statutes to hear noncomplying employer cases. Under ORS 656.704(2), it had authority to hear noncomplying employer cases even though they do not involve matters concerning a claim if there was an arrangement between the Department and the Hearings Division. Review of such cases was to the Court of Appeals. Under ORS 656.740, the Hearings Division was given general authority to hear noncomplying employer cases without mention of whether they concern a claim. No mention was made in that statute of review of noncomplying employer cases. The ambiguity in the statutory scheme lies in the fact that ORS 656.740 provided a specific grant of subject matter jurisdiction to the Hearings Division in two areas, noncomplying employer and penalties, but provided a review process in only one of those areas, penalties. Accordingly, we look to the legislative history for some guidance.

Although the legislative history of the 1981 changes to ORS 656.704 is not crystal clear, the thrust of it is that the Department introduced the amendment in response to the Broadway Cab case to make sure that it had authority to use Hearings Division Referees in cases not involving a claim which would be reviewed under the APA.

> "This is strictly a procedural, permitting us to use referees of the Workers' Compensation Board and establishing the type of APA proceeding that we will have, and which means, basically what we intend to do is use the contested case procedure of the APA going to a referee and then directly to the Court of Appeals, if someone

desires to appeal." Cliff Allison before the Senate Committee on Labor, June 23, 1981.

Thus, the legislative history of the 1981 changes to ORS 656.704 indicates that the changes were intended to allow the Department to use Referees to hear cases not involving a claim which would then be reviewed under the APA by the Court of Appeals. The remaining question is whether the fact that noncomplying employer cases are specifically mentioned in ORS 656.740 without mention of the review process means that noncomplying employer cases are to be treated differently from other cases not involving a claim.

The legislative history of the 1983 changes to ORS 656.740 may provide some enlightenment. The Department's written summary of the then proposed amendment states that the amendment "brings the judicial review procedure under the Administrative Procedures Act...in cases where a non-complying order issued by the department is being contested." However, in the Department's written rationale for the change it states that the current practice is that where "both issues are contested, the one relating to compensability is referred to the Workers' Compensation Board for review, while the matter concerning the noncomplying status of the employer is appealed directly to the Court of Appeals."

Thus, the Department's position on the one hand seems to be that the 1983 amendments bring noncomplying employer appeals under the APA, but on the other hand that they already were under the APA but should be under the Board's review jurisdiction where the case also involves matters concerning a claim.

Because the legislative history is inconclusive, we attempt to give these statutes the most logical reading we can. ORS 656.708 is the general grant of subject matter jurisdiction to the Hearings Division. It has subject matter jurisdiction over matters concerning a claim plus other matters as prescribed by law. ORS 656.726 is the general grant of subject matter jurisdiction to the Board. We have jurisdiction to review hearings on matters concerning a claim as well as such other matters as prescribed by law. ORS 656.704 divides jurisdiction between the Board (including its Hearings Division) and the Department along the lines of matters concerning a claim. However, the Department may arrange to have Hearings Division Referees hear disputes in matters not involving a claim, but review of those hearings is directly to the Court of Appeals. ORS 656.740 (pre 1983) was merely a reference to a specific type of dispute not involving a claim which could be heard by a Referee. The fact that it did not discuss review of noncomplying employer cases does not mean that 656.740 provided an independent grant of subject matter jurisdiction in the Board to review noncomplying employer cases.

We find that the 1983 amendments to 656.740 were merely housekeeping amendments which clarified that review of noncomplying employer cases was to the Court of Appeals unless the case also involved matters concerning a claim, in which case review was to the Board.

We conclude that the relevant statute at the time review was requested in this case was ORS 656.704. This case involved no matter concerning a claim, so it was heard by the Referee under authority of ORS 656.704(2). Because it did not concern a claim, review was properly to the Court of Appeals under the APA. We find no other grant of subject matter jurisdiction in the statutes which would allow us to review this case. Accordingly, we adhere to our original order dismissing this case for lack of subject matter jurisdiction.

We again note that it is unfortunate if the statement at the conclusion of the Referee's order that appeal should be to the Board misled the employer. However, our jurisdiction is solely statutory and incorrect statements of appeal rights cannot expand our jurisdiction.

ORDER

The Board's order of dismissal dated November 22, 1983, as clarified by this order, is reinstated.

MACK E. STONE, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04031
September 28, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee McCullough's order which set aside its denial of claimant's occupational disease claim for "baker's asthma". The issues on review are the timeliness of the claim and compensability.

In 1978 claimant first became aware that he had a condition which was possibly related to his work exposure. The record does not reveal that claimant has ever missed work due to his allegedly work-related asthma. However, in 1981 claimant's doctor informed the employer of the asthma problem and requested that the employer place claimant in a job with less exposure to dust. The employer did so. Claimant did not file a workers' compensation claim against the employer until 1983.

ORS 656.807(1) requires that an occupational disease claim be filed within five years of the last exposure in employment subject to the Oregon Workers' Compensation Act and that it be filed "within 180 days from the date claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease whichever is later." There is no argument that claimant has failed to satisfy the five year requirement. The dispute is whether claimant has satisfied the 180 day requirement. The Referee held that claimant first became disabled in 1981 when the treating doctor requested that the employer reassign claimant to a different job. He thus concluded that claimant did not timely file a claim. The Referee found, however, that the claim was not barred because SAIF was not prejudiced by the late filing.

Since the Referee issued his order, we have held that the date of disability for purposes of the 180 day filing requirement is the date claimant first lost time from work. Charles M. Fox, 36 Van Natta 363 (1984). So far as we can determine from the record, claimant has yet to lose time from work. Accordingly, the

final 180 days has not yet begun to run. Claimant has thus filed his claim in a timely manner. We note that even if we found that the claim was not timely filed, we would agree with the Referee that SAIF has failed to establish that it was prejudiced by any delay.

On the merits of the compensability issue, we affirm and adopt those portions of the Referee's order concerning compensability of the claim.

ORDER

The Referee's order dated March 14, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

A.M. TAYLOR, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-06454 & 83-08820
September 28, 1984
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Howell's order which set aside its denial of further medical treatment for claimant's current low back condition pursuant to ORS 656.245. Claimant contends that the Referee erred in upholding SAIF's denial of a claim for an alleged new injury on July 13, 1983.

The Board affirms that portion of the Referee's order which upheld SAIF's denial of the alleged new injury.

Claimant was initially injured on the job on August 27, 1981 when she felt a pulling sensation while vacuuming hospital rooms. Claimant was diagnosed as having a low back strain and the claim was accepted. On November 11, 1981 Dr. Gulick, claimant's initial treating physician, opined that claimant had no permanent impairment as a result of her compensable injury. He noted that claimant has ongoing degenerative disc disease which is aggravated by her obesity. A Determination Order dated December 10, 1981 granted no award for permanent disability.

Claimant began receiving chiropractic treatments from Dr. Hamilton in December 1981. The chiropractic treatments have continued to date. In March 1983 Dr. Fechtel, D.C. reviewed claimant's medical records for SAIF. He opined that the residuals from claimant's injury had abated by May 1982 and that treatments after that date were unrelated to the compensable injury. On May 23, 1983 Dr. Gulick wrote to SAIF:

> "As I noted in my letters to you of 11/11/81 and 1/25/82, I did not feel there was evidence of permanent impairment at that time. Ongoing therapy for this lady,in my opinion, relates directly to control of her obesity, as I believe that is the primary aggravating factor for her continued back symptoms. I do not feel her back injury of 8/27/81 is the source of her back complaints which have continued to be treated by chiropractic therapy.

"Interestingly, she has had at least two episodes of back pain in the past, according to my record--once on 5/25/81 at which time she had a muscle strain in her back...and previous to that a low back injury in 1962....She has told me she had continued to receive chirporactic therapy since 1962 on an episodic basis for ongoing back pain.

"In summary, I feel that this lady has had back pain long before her injury of 8/27/81. While she did have an exacerbation of her back symptoms after that injury, I do not feel it is the responsibility of SAIF to continue covering her ongoing back pain which I believe is related to circumstances discussed above."

Claimant argues that Dr. Gulick's opinion is undercut by the fact that claimant lost forty pounds during the course of this claim, but continued to have low back symptoms. We are unconvinced by this argument. Despite the loss of weight, claimant's lowest recorded weight is 180 pounds. At that weight she was still described as "overweight."

On May 27, 1983 Dr. Hamilton reported:

"As a result of the accident of August 27, 1981, there has been a weakening of the supportive tissues of the lumbar spine which predisposes [claimant] to occasional exacerbation and worsening that would not afffect a normal individual."

On June 15, 1983, SAIF issued its partial denial of continuing treatments. The Referee found that the course of claimant's complaints was most consistent with Dr. Hamilton's opinion. We disagree. Dr. Gulick was initially claimant's treating physician. He reported that claimant had back problems prior to her compensable injury. He also reported within a few months of the compensable injury that claimant's symptoms were no longer related to the injury. We defer to Dr. Gulick's opinion because he had the opportunity to observe claimant both before and after her compensable injury. He was in the best position to judge whether her condition had returned to its pre-injury state. He found that her condition had returned to its pre-injury state on November 11, 1981, less than three months after the compensable injury. Accordingly, we reverse.

ORDER

The Referee's order dated January 23, 1984 is affirmed in part and reversed in part. That portion of the Referee's order upholding the SAIF Corporation's denial of September 8, 1983 is affirmed. The balance of the Referee's order is reversed. SAIF's denial of June 15, 1983 is reinstated.

CAROLLE J. TUCKER, Claimant
Roll & Westmoreland, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Macdonald, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 83-00889, 83-03022 & 83-03550
September 28, 1984
Order on Review

Reviewed by Board Members Barnes and Lewis.

The SAIF Corporation, insurer for American Care Center, requests review of Referee Shebley's order which set aside its denial of claimant's aggravation claim and upheld a backup denial issued by EBI Companies, insurer for Ebbtide Enterprises, of claimant's alternative new injury claim.

SAIF basically argues that it was relieved of further responsibility when EBI accepted claimant's claim for an injury while working for its insured. Thus, the sole issue on review is the propriety of the Referee's finding that EBI's retroactive denial of claimant's July 1982 injury claim was not prohibited by Bauman v. SAIF, 295 Or 788 (1983).

In January 1982 claimant began working as a nurses' aide at the American Care Center, SAIF's insured. On February 15, 1982 she sustained a low back injury while lifting a patient. The resulting claim was accepted by SAIF and processed to closure by a July 1982 Determination Order which awarded claimant 32° for 10% unscheduled low back disability. Claimant had returned to work with American Care Center in April 1982; however, her employment was terminated about two weeks later for reasons not reflected in this record.

In June 1982 claimant began working as a maid with Ebbtide Enterprises, EBI's insured. After cleaning motel rooms for approximately one month, claimant filed a claim on July 19, 1982 for increased low back pain. No specific injury was identified; however, claimant associated her increased pain with the activity of making beds on or about July 13, 1982. On August 4, 1982 EBI classified the claim as one for disabling injury and deferred action on it. On August 18, 1982 claimant was interviewed by an investigator for EBI. This telephone conversation was tape recorded with claimant's permission, and a transcript appears in this record.

The investigator asked claimant to identify her places of employment prior to working for Ebbtide Enterprises. First she mentioned the American Care Center, and then she mentioned various canneries where she had previously worked. Claimant made no mention of her previous employment with New England Fish Company, where she had sustained an industrial back injury in 1977. She identified her employment at American Care Center as being, "Where my injury originally happened." She described the symptoms she had at the time of that injury in February 1982 and her subsequent hospitalization and recovery. She related that, although she returned to work, she continued to "hurt a lot," and that she continued to administer home treatment such as soaking in a hot bathtub. She indicated that she was getting "progressively sorer" as she performed her maid's job. She stated that her present back problem was the "same, same thing" as her prior back difficulties, i.e. the same kind of pain and the same affected areas.

The investigator asked claimant whether she had experienced any back problem prior to her employment with Ebbtide Enterprises, at which point the interview took the following turn:

> "[Claimant]: Yea, I was born with curvature of the spine and um I guess from what I understand from the doctors that, through history that a curvature of the spine like that will cause a lot of back problems, but the major thing is what their concern is got 2 or 3 disks that are degenerative [sic].
>
> "[Investigator]: So you've had had [sic] some back problems all your life?
> "[Claimant]: Yea, well -- curvature of the spine, yeah.
>
> "[Investigator]: But they really didn't start till you hurt yourself at Seaside?
>
> "[Claimant]: Seaside Care Center.
>
> "[Investigator]: And it's just been something ever since then.
>
> "[Claimant]: Yea."

Claimant also informed the investigator that Dr. Honigman had been responsible for her treatment in connection with her back injury at American Care Center.

On August 20, 1982 claimant was examined by Dr. Jaffin, an orthopedic physician, on referral by Dr. Honigman. Dr. Jaffin's chart note states:

> "[Claimant] was working as a nurses' aide lifting patients and developed severe low back pain four years ago. * * * She sought medical attention with Dr. Catrell [sic] and Dr. Honigman, she had undergone a myelogram two years ago in which they told her there was [sic] severe degenerative changes but there was no impingement upon her nerve roots. She has been treated with courses of physical therapy, bed rest, traction, analgesics, cold packs and hot packs with no relief of her symptomtology [sic]."

The August 20 chart note also records a "chief complaint" of "back -- low -- on job inj. -- lifting patient -- SAIF" and duration of symptoms since "2-15-82," i.e., since the American Care Center injury.

Claimant was seen by Dr. Reimer of the neurological clinic in Portland for eletromyographic and nerve conduction studies on or about August 27, 1982. An out-patient record form apparently completed by Dr. Reimer states: "original on job inj: 2-11-82 Seaside Care Centr * * * thru SAIF * * * inj. at Ebbtide Motel pt. states was result of 1st inj. 7-17-82 * * *."

On September 22, 1982 EBI accepted claimant's claim for injury with Ebbtide Enterprises.

By letter dated January 20, 1983, EBI denied claimant's July 14, 1982 claim ab initio for the stated reason that "the medical information received indicates that your present condition, need for treatment and disability are a result of injuries sustained prior to your employment with Ebbtide Motel."

The Referee concluded that, when EBI accepted claimant's July 1982 claim, it did not have a complete or accurate history and, specifically, had no knowledge of claimant's 1977 industrial injury. He found that EBI did "all that could be reasonably expected" by way of investigation before accepting the claim. The Referee also reasoned: "for whatever reasons, intentional or inadvertent, claimant failed to disclose the 1977 injury or her award of permanent disability compensation which followed." He also concluded that claimant failed to relate her 1977 injury to either Dr. Jaffin or Dr. Reimer. He concluded that these facts were sufficient to allow EBI to issue a backup denial under the "fraud, misrepresentation or other illegal activity" exception articulated in Bauman v. SAIF, supra, 295 Or at 794.

We disagree. We believe that EBI's retroactive denial is prohibited by Bauman because we find that claimant's failure to disclose her 1977 industrial injury did not, under the facts and circumstances of this case, amount to nondisclosure of a material fact.

A failure to disclose a previous injury can be one type of misrepresentation contemplated by Bauman. See Skinner v. SAIF, 66 Or App 467, 470 (1984); Thomas D. Parker, 36 Van Natta 1165 (1984); Robert D. Craig, 36 Van Natta 355 (1984). This case is somewhat similar to Skinner v. SAIF, supra, in which the claimant specifically denied any previous neck injury in response to questioning from at least two physicians. It was undisputed in that case that the claimant had sustained a neck injury in a serious motor vehicle accident several years prior to her industrial injury. The court concluded that the insurer was entitled to retroactively deny the claim.

It is evident from the court's opinion in Skinner that it found that the claimant's previous neck injury was a material fact of which the insurer had no knowledge at the time it was required to make its decision concerning acceptance or denial of the claim. In this case, by contrast, claimant informed EBI's investigator that she had a preexisting back problem related to a fairly recent industrial injury, which claimant said had never resolved but had continued to plague her before and during her employment with EBI's insured. We believe it is consistent with Bauman, if not compelled by Bauman, to require that the insurer establish the colorable materiality of the undisclosed fact, and how its acceptance decision could reasonably have been affected by the insurer's knowledge of that fact.

Our review of the record fails to persuade us that, had claimant informed EBI that her back problems originated with her 1977 industrial injury, rather than her more recent February 1982 injury, EBI's decision to accept the claim would have been any different. What claimant did consistently say to everyone, including the insurer's investigator and her doctors, rather graphically suggests at least the possibility that claimant's late

1982 problems originated with her early 1982 SAIF injury. If EBI did not follow this up with additional investigation, what basis is there for thinking it would have done anything differently had it known of the much older 1977 injury?

We do not agree with the Referee's apparent finding that claimant informed Dr. Jaffin of her February 1982 injury to the exclusion of her 1977 industrial injury. If this were correct, Dr. Jaffin's chart note about claimant's severe low back pain "4 years ago" would make no sense. In addition, Dr. Jaffin was aware that a myelogram was performed on claimant in 1980.

In short, claimant's nondisclosure was immaterial and, therefore, EBI's retroactive denial is precluded by Bauman. It necessarily follows that EBI, rather than the SAIF Corporation, is responsible for payment of claimant's compensation.

ORDER

The Referee's order dated February 16, 1984 is affirmed in part and reversed in part. That portion which set aside the SAIF Corporation's denial dated March 31, 1983 is reversed, and SAIF's denial is reinstated and affirmed. That portion which upheld EBI Company's denial dated January 20, 1983 is reversed. EBI's denial is set aside and this claim is remanded to EBI for further processing and payment of compensation to claimant. EBI shall reimburse SAIF for all claim costs paid in reliance on the Referee's order. The remainder of the Referee's order is affirmed.

WILLIAM J. ANDERSON, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-07774
July 11, 1984
Order of Abatement

The Board has received the insurer's motion to reconsider our Order on Review dated June 22, 1984.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE SUPREME COURT OF THE STATE OF OREGON

SHAW,
Respondent on Review,
v.
DOYLE MILLING COMPANY, INC.,
Petitioner on Review.
(No. 81-239; CA A25795; SC S30279)

In Banc

On review from the Court of Appeals.*

Argued and submitted April 5, 1984.

John A. Hudson, Eugene, argued the cause for petitioner on review. With him on the briefs was Hudson & Kearney, P.C.

Michael R. Stebbins, North Bend, argued the cause for respondent on review. With him on the brief was Hayner, Waring, Stebbins & Coffey.

LENT, J.

Affirmed.

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* Appeal from judgment of the Circuit Court for Coos County, Robert F. Walberg, Judge. 65 Or App 814, 671 P2d 1211 (1983).

LENT, J.

This is a suit for injunctive and other relief under ORS 659.121 for an alleged violation of ORS 659.415. At the time with which this case is concerned, those statutes provided:

ORS 659.121(1):

"Any person claiming to be aggrieved by an unlawful employment practice prohibited by ORS * * * 659.415 * * * may file a civil suit in circuit court for injunctive relief and the court may order such other equitable relief as may be appropriate, including but not limited to reinstatement or the hiring of employes with or without back pay. * * * In any suit brought under this subsection, the court may allow the prevailing party costs and reasonable attorney fees."

ORS 659.415:

"(1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment or employment which is available and suitable upon demand for such reinstatement, provided that the worker is not disabled from performing the duties of such position. A certificate by a duly licensed physician that the physician approves the worker's return to the worker's regular employment shall be prima facie evidence that the worker is able to perform such duties.

"(2) Any violation of this section is an unlawful employment practice."

The general issue is whether an employer must reinstate a worker to his former position of employment under ORS 659.415, where the employer has hired another employee to fill the position during the absence of the worker who had exercised his rights under the Workers' Compensation Law. We hold that it must. The particular issue is whether this plaintiff (Shaw) had to prove that his demand for reinstatement would not have been denied "but for" unlawful discriminatory motive on the part of defendant (Employer). We hold that he did not.

Shaw commenced employment at Employer's veneer mill in September, 1978. He worked as leadman[1] on the

greenchain. The mill had periodic temporary layoffs. On November 14, 1979, Shaw and the other employees were laid off for an indefinite period. On December 10, 1979, Shaw applied for workers' compensation benefits for a compensable injury. On December 11, 1979, the mill reopened, but Shaw did not return to work because of his injury. On February 13, 1980, Shaw was released by his physician to return to his regular employment. On that same day he made demand for reinstatement to his former position. While he was off work due to the compensable injury, Employer had replaced him with another worker as leadman on the greenchain. Employer failed to reinstate Shaw to any position.

Shaw again became unable to work on September 26, 1980. There is no evidence that Shaw has again been released by a physician to return to work. By the date of trial, Employer had ceased ownership and operation of the mill. For those reasons, reinstatement of Shaw by the circuit court to his former position was then impossible.

The circuit court calculated the number of working days between February 13, 1980, and September 26, 1980, and subtracted days the mill was shut down. The court multiplied the result by Shaw's former daily wage. From the product, the sums for unemployment benefits and compensation from Shaw's other employment during the period were subtracted. The result was the amount the trial court found as lost wages. This amount, $4,152.51, was awarded to Shaw, in addition to $4,473.26 in attorney fees, costs and disbursements. The Court of Appeals affirmed without opinion.

This court has recognized a general rule that:

> "[I]n the absence of a contract or statute to the contrary, an employer may discharge an employee at any time and for any cause."

Yartzoff v. Democrat-Herald Publishing Co., 281 Or 651, 655, 576 P2d 356 (1978).[2] ORS 659.415 requires an employer to reinstate an injured worker to the worker's former position unless he is disabled from performing it. This court has equated a refusal to reinstate with a "discharge." *Vaughn v.*

[1] There was undisputed evidence that the leadman position involved duties and skills other than those of other employees who worked on the greenchain and that not all employees who worked on the greenchain were capable of filling the leadman position.

[2] We have noted, however, that the general rule is falling into disfavor in many states. *See, e.g., Delaney v. Taco Time Int'l.*, 297 Or 10, 14, ____ P2d ____ (1984).

Pacific Northwest Bell Telephone, 289 Or 73, 79, 611 P2d 281 (1980). Thus, ORS 659.415 constitutes a statutory exception to the general rule that an employer may discharge a worker at any time and for any cause.

Employer argues that where filling the position with another worker is necessary to operation of the enterprise, the situation is the same as would be the case where the position has been completely abolished by management utilization of technological advances. The latter situation is not before us and is not here decided. As to the situation that is before us, Employer argues that the legislature could not have intended reinstatement where a short-time employee is disabled by job injury, is off work two years and then returns to claim the position from one who has been necessarily employed in that position during that period. That argument is addressed to legislative wisdom, and it is not for this court to respond.

The main purpose of ORS 659.415 is to guarantee that an employer shall not discriminate against a disabled worker for exercising the worker's rights under the Workers' Compensation Law. This statute is but one of a set of statutes reflecting the legislature's concern to prohibit employment discrimination on the basis of handicap. *Vaughn v. Pacific Northwest Bell Telephone, supra,* 289 Or at 88. Where the position still exists, although filled by another employee, the returning employee is entitled by the statutory text to reinstatement. To hold otherwise would permit an employer unilaterally to vitiate the mandate of ORS 659.415 and to thwart the broader legislative scheme to afford employment opportunity and security to the handicapped.

Employer argues that under our decision in *Vaughn v. Pacific Northwest Bell Telephone, supra,* Shaw cannot prevail because he did not prove that he would not have been discharged "but for" a discriminatory motive of his employer. In *Vaughn* we stated:

> "If the worker is discharged for just cause, the employer can prove this * * * as a matter of defense in a suit pursuant to ORS 659.121."

289 Or at 80. We formulated the "just cause" issue:

> "The question then is what effect the employer's evidence of just cause for discharge has on the court's remedial authority in ORS 659.121(1)."

289 Or at 90. We did state that in cases of mixed motives for the discharge, i.e., where the discharge is motivated in part by poor work record or misconduct and in part by unlawful discrimination by the employer, the employee could not prevail unless the court

> "finds that the employee would not have been discharged but for the unlawful discriminatory motive of the employer."

289 Or at 92. In the case at bar the invocation of that language from *Vaughn* is of no avail.

In *Vaughn* we reversed a summary judgment for the employer and remanded to the trial court to find the reason(s) for discharge. The instant case has already been tried as a suit in equity. The trial judge found, based on the evidence, that reinstatement was denied because Employer would not displace the worker who performed the duties of the position during Shaw's absence. We assume that by affirming the trial court the Court of Appeals made the same finding. ORS 19.125(3) provides that upon appeal from a decree in a suit in equity the Court of Appeals shall try the cause anew upon the record.

There is evidence that persuades us to the same result. ORS 19.125(4). During trial, the following testimony was adduced as Employer's counsel cross-examined Mr. Sidney Lansing, former comptroller of Employer:

> "Q. When * * * Shaw came back on the 13th, between the 13th of February and the 17th of March, was — was someone else in his position?
>
> "A. Oscar Sapp.
>
> "Q. Okay. And had that position been available up until the time just before you started these other things and had questions arise, would he [Shaw], as far as you know, been hired back at that time?
>
> "A. Yeah, I would have hired him if it had been that way. I didn't have any indication not to."

Employer's reason for not reinstating Shaw was that his position had been filled with another employee. This reason does not constitute "just cause" for refusing to reinstate or for discharging Shaw. If Shaw had remained at work instead of pursuing a workers' compensation claim, he would not have been discharged. If his position had not been filled, he would have been reinstated upon his release to return to work.

In the instant case, Employer did not establish any just cause for discharge; therefore, Shaw did not have to show that he would have been reinstated "but for" Employer's unlawful employment practice.

The decision of the Court of Appeals is affirmed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation
of Harold Curry, Claimant.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent on Reconsideration/
Petitioner on Review,

v.

CURRY,
Petitioner on Reconsideration/
Respondent on Review.

(WCB 81-021CA A27159; SC S30183)

In Banc

On respondent's motion for reconsideration of Supreme Court order of February 22, 1984, denying respondent's petition for attorney fees. Motion for reconsideration allowed April 20, 1984.*

Argued and submitted July 10, 1984.

J. Michael Alexander, Burt, Swanson, Lathen, Alexander and McCann, Salem, for petitioner on reconsideration.

Donna Parton Garaventa, Assistant Attorney General, Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem, for respondent on reconsideration.

James S. Coon, Welch, Bruun and Green, Portland, filed a brief amicus curiae for Oregon Worker's Compensation Attorneys.

Allan M. Muir, Schwabe, Williamson, Wyatt, Moore & Roberts, Portland, filed a brief amicus curiae for Association of Workers' Compensation Defense Attorneys. With him on the brief were Roger A. Luedtke and Ridgway K. Foley, Jr., P.C.

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* Judicial review of order of Workers' Compensation Board, 65 Or App 230, 670 P2d 1074 (1983). Petition for review denied January 24, 1984.

LENT, J.

Petition for attorney fees denied.

LENT, J.

The issue is whether under ORS 656.382(2) a workers' compensation claimant is entitled to an award of attorney fees for work done in response to an insurer's petition for review which is ultimately denied. The legal services which generated this claim for fees arose from our request that claimant's attorney prepare a response to SAIF's petition for

review of a Court of Appeals decision.[1]

The statute in question, ORS 656.382(2), provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals *or petition for review to the Supreme Court* is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney's fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal." (Emphasis added.)

The emphasized language is the pertinent part of the amendments to ORS 656.382(2) enacted by Or Laws 1983, ch 568, § 1(2).

The course of this litigation is that claimant was found to be permanently and totally disabled by the Workers' Compensation Board in its exercise of its own motion jurisdiction. SAIF appealed to the Court of Appeals, which affirmed without opinion, and SAIF then petitioned this court for review. After receiving the response from claimant, we denied the petition.

We previously discussed the history and purpose of ORS 656.382(2) in *Bracke v. Baza'r,* 294 Or 483, 658 P2d 1158 (1983). We shall not repeat that discussion here. One purpose of the statute is to discourage employers or their insurers from wearing down claimants with harassing and frivolous appeals.

The statute does this by providing for an award of attorney fees to the claimant if an employer or insurer initiates a higher level examination of the case and does not win a reduction or elimination of the claimant's award. *Bracke,* 294 Or at 487.

As we determined in *Bracke,* because of an apparent legislative oversight,[2] the statute, as it existed prior to amendments by the 1983 legislature, did not permit attorney fees to be awarded by this court to claimant's attorney for work done at the Supreme Court level. *Bracke,* 294 Or at 490. For this reason, if claimant is to prevail it must be because the amendments enacted in 1983 so permit. These amendments, *inter alia,* made a petition for review to the Supreme Court a type of employer initiated action which could trigger a possible award of attorney fees.

The question is to determine if our denial of review fits the statutory predicate for awarding attorney fees if this

[1] Claimant's attorney originally filed a one-half page response to the petition, addressing a procedural aspect of the case, in which he "reserved the right to file a substantive response if review should be accepted." This court, desiring to have the attorney's views, at which he hinted, then asked for his further response. Fees for the services performed by claimant's attorney with respect to the second response are the subject of this case.

[2] In 1977 the legislature repealed ORS 656.301 as part of a general attempt to bring ORS chapter 656 into harmony with the statutes which had created the Court of Appeals several years earlier. That action, however, removed any reference to the Supreme Court from ORS chapter 656 and led to our conclusion in *Bracke v. Baza'r,* 294 Or 483, 658 P2d 1158 (1983), that we could not award attorney fees for work done at the Supreme Court level.

"* * * court *finds* that the compensation awarded to claimant should not be disallowed or reduced * * *." ORS 656.382(2). (Emphasis added.) SAIF argues that we have not made a finding and, therefore, we are powerless to award such fees to claimant.

We explained the want of significance to be attached to a denial of a petition for review in *1000 Friends of Oregon v. Bd. of Co. Commissioners*, 284 Or 41, 584 P2d 1371 (1978). We said that "a denial of review carries no implication that the decision or the opinion of the Court of Appeals was correct." *1000 Friends* at 44. After explaining some of the numerous reasons which might cause us to deny review even if we disagreed with a Court of Appeals decision, we said:

> "* * * denial of review * * * may not be taken as expressing even a slight sign that this court approves the decision or the opinion of the Court of Appeals."

284 Or at 45.

We iterated the limited significance to be attached to a denial of review in a later case, *U-Cart Concrete v. Farmers Ins.*, 290 Or 151, 619 P2d 882 (1980), in which we were dealing with the question of whether the respondent to a petition for review which is denied could be awarded costs and disbursements under a different statute as a "prevailing party." We said:

> "In denying a petition for review, we neither affirm nor reverse a judgment. We do not even implicitly decide that the respondent's position is correct or that the Court of Appeals properly decided the case. [Citations omitted.]
>
> "When a petition for review is denied the respondent has not prevailed 'on an appeal' in this court. Rather, the court has chosen not to entertain an 'appeal.' " (Footnote omitted)

290 Or at 154.

Although the statute before us in this case requires neither a "prevailing party" nor a "judgment or decree" as was required in *U-Cart*, we find the reasoning of *1000 Friends* and *U-Cart* persuasive. By denying an employer's petition for review in a workers' compensation case, we do not "find" that compensation should not be disallowed or reduced.

As a matter of a literal reading of ORS 656.382(2), we conclude that we have no basis to award attorney fees in this case.

Our inquiry, however, does not end there. As we have said many times, it is the duty of this court in construing a statute to ascertain the intent of the legislature in enacting it and to refuse to adopt a literal interpretation when to do so would produce an "absurd or unreasonable result." *See Pacific P. & L. v. Tax Com.*, 249 Or 103, 110, 437 P2d 473 (1968), and cases cited therein. Applying the text of this statute produces neither an absurd nor unreasonable result, and a study of legislative intent makes that clear. Our inquiry into legislative intent is limited to the 1983 amendments to ORS 656.382(2) because, as we determined in *Bracke*, there was no provision for attorney fees to be awarded for work at the Supreme Court level under the statute as it existed prior to the 1983 amendments.

The amendments to ORS 656.382(2) were enacted by Or Laws 1983, ch 568, § 1(2), which emerged from the Senate

Labor Committee in its final form; therefore, the debate and testimony before that committee are instructive as to the intent of the legislature in amending the statute.

The minutes of the Senate Labor Committee reveal that the members were specifically concerned with the results of three court decisions which had discussed attorney fees in relation to workers' compensation cases. One of those cases was *Bracke v. Baza'r, supra.* The others do not concern us here.[3] In addition, the committee considered, but rejected, a proposal that would have allowed an award of attorney fees to a claimant's attorney who works on an appeal initiated by an employer or insurer, but which is dismissed on the employer/insurer's motion prior to a decision. The committee members' rejection of this proposal is consistent with a generally limited goal in amending ORS 656.382(2).

From our review of the committee proceedings, we are convinced that the committee intended to modify the statute only to the degree necessary to allow claimants in specified situations to obtain attorney fees. The members were particularly concerned with amending the statute to eliminate the problem which led to our holding in *Bracke* that a claimant who prevailed in the Supreme Court after allowance of an employer's petition for review could not win attorney fees. They rejected the only proposal which would have granted attorney fees if an employer initiated an appeal or petition for review, but the case did not proceed to a final judgment in the higher court. We conclude, therefore, that the intent of the legislature in passing the 1983 amendments to ORS 656.382(2) was to allow attorney fees in Supreme Court cases only when this court actually allows an employer's petition for review and decides that theretofore awarded compensation should not be disallowed or reduced.

We recognize that this result is harsh for claimant's attorney in this case. In the usual situation where an employer

or insurer petitions for review, the claimant/respondent is not required to provide substantial additional legal services until and unless we decide to accept review. If the claimant successfully defends his award before this court, he is entitled to attorney fees. Here, the normal pattern was not followed because we requested that claimant provide a response. In this instance his work will go uncompensated; however, our ability to award attorney fees in workers' compensation cases is limited to the authority granted by statute. In this case we

[3] The other cases were *Paresi v. SAIF,* 62 Or App 139, 660 P2d 682 (1983), and *Teel v. Weyerhaeuser Co.,* 58 Or App 564, 649 P2d 610 (1982). The holding of the Court of Appeals in *Teel,* denying attorney fees to claimant when an employer initiates a cross-appeal, was reversed by this court on March 22 (294 Or 588, 660 P2d 155 (1983)), several weeks before the Senate Labor Committee held its first work session on SB 589. Nevertheless, the committee amended the statute to specifically allow compensation for attorney fees incurred in response to an employer's unsuccessful cross-appeal.

have no authority and must refuse to make an award. The remedy, as always, lies with the legislature.[4]

The petition for attorney fees is denied.

[4] Having disposed of this case on the basis set forth in the text of this opinion, we do not reach SAIF's further argument that the statute allows award of a reasonable fee only for "legal representation * * * at and prior to the hearing, review on appeal or cross-appeal" and that services in the Supreme Court are not included therein. The argument is that the reference to "hearing" applies to a hearing before a referee and that the reference to "review on appeal and cross-appeal" refers to proceedings at the Court of Appeals level. If the legislature should desire to provide for an award of attorney fees in the situation presented by the case at bar, it should direct its attention to the full text of ORS 656.382(2).

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Wilma Forney, Claimant.

FORNEY,
Petitioner on review,
v.
WESTERN STATES PLYWOOD,
Respondent on review.

(WCB 80-07538; CA A25760; SC S30476)

In Banc

On review from the Court of Appeals.*

Argued and submitted June 6, 1984.

Evohl F. Malagon, of Malagon & Associates, Eugene, argued the cause and filed the petition for petitioner on review. On the brief was David C. Force, Eugene.

J. P. Graff, of Schwabe, Williamson, Wyatt, Moore & Roberts, Portland, argued the cause for respondent on review and filed the brief.

JONES, J.

The Court of Appeals is affirmed.

* Judicial review from order of Workers' Compensation Board. 66 Or App 155, 672 P2d 1376 (1983).

JONES, J.

The issue in this case is whether claimant is entitled to attorney fees when she prevails in her contention that her employer erroneously unilaterally deducted overpayment of earlier compensation from her subsequent workers' compensation award.

Claimant injured her back in 1974. A determination order awarded her 20 percent for unscheduled permanent partial disability. Employer paid this award. That order was later set aside and a new order was entered in 1978 which again granted an award for 20 percent permanent partial disability. Employer paid that award. Thus, employer twice paid the same award, creating an overpayment.

In 1979, claimant filed an aggravation claim which employer denied. Claimant requested a hearing on the denial. In 1980, the referee ordered employer to accept the claim and pay benefits. Employer did not request review of the referee's order. While processing payment in accordance with the 1980 order, employer discovered the earlier double payment and reduced each payment due under the 1980 aggravation claim until the entire overpayment was recovered.

Claimant requested a hearing pursuant to ORS 656.283(1). At the hearing claimant challenged employer's right to recover the overpayment. The referee found that there had been an overpayment and employer was entitled to recover it. The Workers' Compensation Board affirmed the referee. The Court of Appeals reversed on the ground that the Workers' Compensation Department exceeded its authority in adopting a regulation which permitted recovery of overpayments without prior authorization from the Department, a referee or the Board. Employer was ordered to repay the recovered overpayment.

Claimant then petitioned for attorney fees pursuant to ORS 656.386(1). Employer filed objections to claimant's petition and the Court of Appeals denied claimant's petition. Claimant petitioned this court for review of the Court of Appeals denial of her petition for attorney fees.

Claimant contends that attorney fees should have been awarded pursuant to ORS 656.382(1) and (2) and ORS 656.386(1). ORS 656.382 provides:

> "(1) If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney's fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees.
>
> "(2) If a request for hearing, request for review or court appeal is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney's fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at the hearing, review or appeal."

Claimant argues that she was entitled to benefits and employer withheld the benefits which were due and payable under the 1980 aggravation claim and, therefore, she is entitled to attorney fees under ORS 656.382(1).

Employer makes two arguments regarding ORS 656.382. First, in recovering the overpayment which claimant conceded she had received, employer acted in accordance with regulations of the Workers' Compensation Department and therefore employer's conduct was reasonable. Second, it was claimant, not employer or insurer, who requested the hearing, board review and court appeal and ORS 656.382(2) provides for attorney fees only where employer or insurer initiates the request.

Claimant also contends that attorney fees should be awarded pursuant to ORS 656.386(1), which provides:

> "In all cases involving accidental injuries where a claimant prevails in an appeal to the Court of Appeals from a board order denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee; however, in the event a dispute arises as to the amount allowed by the referee or board, that amount may be settled as provided for in ORS 656.388(2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

Claimant contends that this is a claim involving her right to compensation previously awarded and, therefore, she is entitled to attorney fees under ORS 656.386(1).

We note that the appeal in this case was not from a board order denying a claim for compensation, but from an order sustaining employer's recovery of the overpayment under the Department's regulation. Claimant's only claim was for the amount of compensation due on her aggravation claim. Where responsibility is not an issue and the only question is the amount of compensation due, ordinarily attorney fees are not authorized under ORS 656.386(1) and can only be recoverable from the award under ORS 656.382(2).

It is fundamental that the legislature provides rights and remedies for workers and employers. This court cannot exceed the legislative limitations even though an inequity to the employe or to the employer might result. Unless a specific statute authorizes an award of attorney fees to a claimant, this court cannot award them. *Brown v. EBI Companies,* 289 Or 905, 618 P2d 959 (1980). In examining the first statute claimant relies upon for an award of attorney fees, we note that ORS 656.382(1) provides for attorney fees if a self-insured employer refuses to pay compensation due under an order of a referee, board or court. In this case, the employer never refused to pay compensation due under an award of the referee or the board. In fact, both the referee and the board ruled that the employer was specifically authorized to recover the overpayment under an existing administrative rule.[1] This

[1] OAR 436-54-320 provides:

"Insurers and self-insured employers may recover overpayment of benefits paid to a worker on an accepted claim from benefits which are or may become payable on that claim. Payment of benefits paid prior to denial pursuant to ORS 656.262(5) or paid during appeal pursuant to ORS 656.313 shall not be recoverable under this section.

"(1) Overpayments may be recovered by:

"(a) reduction of continuing temporary disability benefits in an amount not to exceed 25 percent of the benefit without prior authorization from the worker or beneficiary;

"(b) withholding reimbursement of related services to the worker; or

"(c) adjustment in compensation benefits determined due pursuant to ORS 656.268, to include permanent partial disability, permanent total disability and fatal disability benefits. Recovery of overpayment from a permanent partial

rule was declared invalid by the Court of Appeals in this case, but that decision did not require the employer to pay any additional compensation declared due by the Court of Appeals. Therefore, the first portion of ORS 656.382(1) is inapplicable to this worker's claim for attorney fees.

The second portion of ORS 656.382(1) provides that the self-insured employer shall be liable for attorney fees if it otherwise unreasonably resists the payment of compensation. It would be absurd to rule that an employer has unreasonably resisted payment of compensation when the employer in good faith relied on an administrative rule and legal orders from the referee and, subsequently, the Workers' Compensation Board that the overpayment recovery was proper. Since there has been no unreasonable refusal to pay any compensation as ordered by the Court of Appeals, this second portion of ORS 656.382(1) is also inapplicable to the worker's claim for attorney fees.

Claimant's final contention for attorney fees is that attorney fees are recoverable in this case under ORS 656.386(1). This statute is also infructuous as far as claimant is concerned. It provides that in all cases where claimant prevails in an appeal to the Court of Appeals from a board order denying the claim for compensation, the court shall award a reasonable attorney fee. In this case the claimant did not prevail from any board order denying a claim for compensation. The board had awarded compensation and had approved the withholding of overpayment. The Court of Appeals simply struck down that ruling in declaring the board's administrative rule invalid.

Since claimant is restricted to a statutory remedy and none is available, the Court of Appeals' denial of the worker's petition for attorney fees was legally correct. If this has resulted in an inequity to the worker in this case and is likely to affect many similar claims, that inequity must be corrected by the legislature and not by this court.

We affirm.

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disability award may result in partial or total offset against the award. Recovery from a permanent total disability or fatal award shall be made as in (a) above.

"(2) Recovery of overpayment by the insurer or self-insured employer shall be explained in written form to the worker, or to the dependent(s) of the worker if a fatality, and include:

"(a) an explanation for the reason of overpayment;

"(b) the amount of the overpayment; and

"(c) the method of recovery of the overpayment.

"(3) Overpayments may not be recovered by withholding payments to the providers of services or from reimbursable temporary disability paid during an approved vocational rehabilitation program."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paul Stiennon, Claimant.

STIENNON,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(82-02978; CA A29158)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 10, 1984.

Mike Stebbins, North Bend, argued the cause for petitioner. With him on the brief was Hayner, Waring, Stebbins & Coffey, North Bend.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause for respondent. On the brief was Donna Parton Garaventa, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

In this aggravation claim, claimant appeals an order of the Workers' Compensation Board which reversed the referee and held that claimant is not entitled to temporary total disability (TTD), because he had retired prior to the date on which the claimed time loss occurred. We affirm.

Claimant sustained a compensable injury to his right knee on August 30, 1979. He turned 65 on December 7, 1979, and applied for his retirement in February, 1980. Since that time he has been receiving Social Security and his work-related pension. A determination order eventually awarded claimant time loss from December 5, 1979, through August 8, 1980, and 20 percent scheduled disability for injury to his right leg. Claimant requested a hearing on that determination order, and on April 6, 1981, the parties entered into a stipulation under which claimant received an additional 10 percent scheduled disability.

Claimant continued to have difficulty with his right knee and eventually surgery was scheduled for April 1, 1982. Before the surgery was performed, SAIF advised claimant that, although it would pay for the surgery because it was related to the compensable condition, it would not pay any TTD "as there is no loss of wages involved." After a hearing, the referee held that claimant was entitled to TTD from April

1, 1982, through August 9, 1982, and awarded a penalty of 25 percent for SAIF's unreasonable refusal to pay. The Board reversed, holding that claimant was not entitled to any time loss "because of prior retirement." Claimant appeals, contending that, even if he has retired, he is entitled to TTD and, in the alternative, that he is not, in fact, retired.

Temporary total disability payments are authorized by ORS 656.210(1), which states in pertinent part:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation * * *."

Claimant relies on *Stone v. SAIF,* 57 Or App 808, 646 P2d 668 (1982), *rev den* 294 Or 442 (1983), which holds that an employer's liability for interim compensation is not affected by the fact that the employe has retired. That case is not controlling, however, because we have recognized that there is

a distinction between an employer's liability for TTD and its liability for interim compensation. *Bono v. SAIF,* 66 Or App 138, 141-42, 673 P2d 558 (1983), *rev allowed* 296 Or 829 (1984). The purposes of the two types of compensation are different. Interim compensation was devised

> "primarily to induce insurers to deny a claim promptly or be required to pay interim compensation, regardless of the validity of the claim. It is not really payment for compensable loss; its function is to protect a claimant against unreasonable delay in processing the claim. * * *" *Bono v. SAIF, supra,* 66 Or at 143.

Consistent with that holding as to the purpose of interim compensation are the cases in which it has been held that liability for interim compensation is not affected by the fact that the claimant has retired, *Stone v. SAIF, supra,* is actually working for pay during the period of interim compensation, *Bono v. SAIF, supra,* or even by the fact that the claim is later held to be noncompensable *in toto. Jones v. Emanuel Hospital,* 280 Or 147, 151-52, 570 P2d 70 (1977).

The same reasoning does not apply to a claimant's entitlement to TTD, the purpose of which is to compensate a claimant "for loss of income until claimant's condition becomes stationary in order to enable claimant to support self and family during that period." *Taylor v. SAIF,* 40 Or App 437, 440, 595 P2d 415, *rev den* 287 Or 477 (1979); *see also Hedlund v. SAIF,* 55 Or App 313, 317, 637 P2d 1329 (1981). Provision is expressly made in the statute for no TTD for the first three calendar days of time loss, unless the disability continues for a period of 14 days or the worker is in the hospital. ORS 656.210(3). In addition, the amount of the TTD payment is reduced if the claimant's inability to work is only partial. ORS 656.212. The entire statutory scheme illustrates that TTD was established for the purpose of compensating a claimant for wages lost because of inability to work as a result of a compensable injury. If the claimant has retired voluntarily following the injury, he can suffer no loss of wages, because, by definition, he has no expectation of receiving wages. The Board did not err in holding that claimant is not entitled to TTD for the period covering his surgery and his recovery therefrom if he had already retired.

Claimant's second argument is that, although he had been receiving social security and a work-related pension for

two years, he, in fact, had not retired. He contends that he had a part-time job as a carpenter for which he was paid $8.50 an hour. The only evidence on this point is claimant's testimony that he was paid for a total of six hours of work. We conclude that the record as a whole establishes that claimant has retired. The fact that he may accept an occasional odd job does not detract from that conclusion. He is, therefore, not entitled to any TTD other than that already awarded by the determination order.[1]

Affirmed.

[1] SAIF has not challenged claimant's entitlement to TTD up to the date on which he was determined to be medically stationary, even though that date was after he had retired. We note that it would be virtually impossible to determine whether claimant had retired because his physical condition was unstable and he was unable to work, or whether he decided to retire without regard to his physicial condition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charles W. Roller, Claimant.

ROLLER,
Petitioner,
v.
WEYERHAEUSER COMPANY,
Respondent.

(83-00383; CA A26151)

Judicial Review from Workers' Compensation Board.

On respondent's petition for reconsideration filed May 7, 1984. Former opinion filed April 11, 1984, 67 Or App 583, 679 P2d 341.

Mildred J. Carmack, Portland, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reconsideration allowed; former opinion amplified; as so amplified, adhered to.

BUTTLER, P. J.

We allow employer's petition for reconsideration in order to amplify the basis for our original opinion, *Roller v. Weyerhaeuser Co.*, 67 Or App 583, 679 P2d 341 (1984), and, with that amplification, we adhere to that opinion.

Employer's "partial denial" here was, in effect, an attempt to effect an employer closure, which is authorized by ORS 656.268(3). As we pointed out in our opinion, however, employer treated its "partial denial" as just that, not as a closure, and it did not comply with the notice provisions required by the statute for employer-insurer closures. The procedures are different. For example, with respect to a denied claim, a claimant must generally file a request for hearing within 60 days, ORS 656.319(1)(a), whereas he has one year after notice of claim closure within which to request a determination order from the Evaluation Division. ORS 656.268(3).

Our original opinion held that employer may not shortcut the statutory procedure for closing the claim by use of the "partial denial" it used in this case. We adhere to that opinion.

Reconsideration allowed; former opinion amplified; as so amplified, adhered to.

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822 June 27, 1984 No. 394

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Anna M. Scheidemantel, Claimant.

SCHEIDEMANTEL,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(81-00719; CA A28809)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 13, 1984.

David C. Force, Eugene, argued the cause and filed the brief for peitioner.

Donna Parton Garaventa, Associate Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for respondent.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Affirmed in part; reversed in part; and remanded.

VAN HOOMISSEN, J.

Claimant appeals from an order of the Workers' Compensation Board. She contends that the Board erred in affirming SAIF's termination of her temporary total disability payments and in denying her aggravation claim. On *de novo*

review, we affirm the denial of the aggravation claim. We reverse and remand to the Board to determine when temporary total disability payments should have ceased and whether a penalty and attorney fee should be awarded. ORS 656.298(6).

Claimant sustained a compensable back injury in 1979. She was treated for a dorsolumbar strain and was determined to be medically stationary in 1980. Later, she made an aggravation claim that resulted in a stipulated award of 7.5 percent unscheduled permanent partial disability. In April, 1981, her attending physician, Dr. Cox, admitted her to a hospital for evaluation. She was diagnosed as having chronic back pain, cause undetermined. After being billed for that treatment, SAIF denied responsibility. It alleged that, if in fact her condition had worsened, it was due to a mud-wrestling incident in which she had participated.

The referee found that claimant was not entitled to temporary total disability compensation and affirmed SAIF's denial of her aggravation claim. The Board affirmed the referee's denial of the aggravation claim but found SAIF liable for disability payments from the time of her April, 1981, hospitalization until she was released to return to work by Dr. Golden in July, 1981.

Claimant argues that the Board improperly relied on Dr. Golden's report because he was SAIF's medical examiner and not her attending physician. *See* ORS 656.268.[1] ORS 656.005(13) provides, in relevant part:

> "* * * 'Attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury. 'Consulting physician' means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician regarding treatment of a worker's compensable injury."

Clearly, Dr. Cox had been claimant's attending physician.[2]

We conclude that Dr. Golden was merely a consulting physician. He did not treat claimant. He advised Dr. Cox as to the etiology of her back problems. He conducted a second

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[1] ORS 656.268 provides, in relevant part:

"(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary * * *."

"(2) * * * If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section."

[2] In *Kemp v. Workers' Comp. Dept.*, 65 Or App 659, 667, 672 P2d 1343 (1983), *modified on other grounds*, 67 Or App 270, 677 P2d 725, *rev den* 297 Or 227 (1984), we stated:

"ORS 656.245(3) implies that a claimant can have only one attending phyician at a time. OAR 436-69-401(1) and (2) are consistent with that implication. The only additional requirement, that a new attending physician notify the insurer not later than five days after the date of first treatment, is merely one method of enforcing the implied directive of ORS 656.245(3) and is consistent with the legislative policy. OAR 436-69-401(1) and (2) are within the authority of the Department and are valid." (Footnote omitted.)

examination at the request of Dr. Cox and SAIF. He then reported that claimant should be able to return to "some kind of work."[3] Because Dr. Golden was a consulting physician, SAIF had no right to rely on his conclusion that claimant could return to work in stopping temporary total disability payments.

Claimant's aggravation claim was not denied by SAIF until December, 1981. Temporary total disability payments ceased, however, in July, 1981. Therefore we reverse and remand to the Board to determine when her temporary total disability payments should have ceased and whether a penalty and attorney fee should be awarded.

The other issue is claimant's aggravation claim. The referee found that there was insufficient medical evidence from which to conclude that her condition had worsened since

her last award or arrangement of compensation, ORS 656.273(1), or that the original 1979 injury was a material contributing cause of her April, 1981, aggravation. The Board agreed. It found:

> "Virtually every physician who has treated or examined claimant has been unable to find any objective evidence to substantiate her physical complaints; virtually every physician has felt that she was exaggerating her problem. This view is shared by the physicians who examined and treated claimant during her December 1980 and April 1981 hospitalizations. Additionally, with regard to claimant's April 1981 hospitalization, we find that claimant has not established that the 1979 industrial injury was a material contributing cause of the condition for which she was then treated. There is no statement from any physician indicating that the 1979 injury, as opposed to claimant's mud-wrestling activity prior to her April 1981 hospitalization, was a material cause of her exacerbated condition."

Throughout the course of claimant's treatment, there has been a paucity of medical evidence establishing the physical cause of her disability. Dr. Cox could not determine the cause. He referred claimant to Dr. Golden, who refused to diagnose her condition beyond stating that she was suffering from a strained back. Dr. Whitney diagnosed a back strain. He reported, however, that a physical examination showed a completely normal back. A myelogram showed no evidence of disc disease. Claimant has the burden to show through medical evidence a worsening of her underlying condition, not merely an aggravation of her symptoms. *Sheffield v. SAIF*, 50 Or App 427, 429, 623 P2d 1082 (1981). We conclude that she has failed to sustain her burden of proof.[4] We affirm the denial of the aggravation claim.

Affirmed in part; reversed in part; and remanded.

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[3] Dr. Golden reported:

> "My previous evaluation left the impression that this lady probably had a significant amount of functional overlay. I am unable to find any significant pathology and although she may have chronic lumbosacral spine strain, I am certain that she should be able to return to some kind of work without fear of aggravating an undiagnosed condition."

[4] Claimant contends that the Board shifted the burden to her to prove that the mud-wrestling incident was not the major contributing cause of her problem. We do not read the Board's order as shifting the burden of proof.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Richard L. Folkenberg, Claimant.

FOLKENBERG,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent.

(82-07457; CA A29909)

Judicial Review of the Workers' Compensation Board.

Argued and submitted March 12, 1984.

Steven P. Pickens, Medford, argued the cause and filed the brief for petitioner.

Donna Parton Garaventa, Assistant Attorney General, Salem, argued the cause for respondent. With her on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

WARDEN, J.

Reversed and remanded with instructions to reinstate referee's order.

WARDEN, J.

Claimant appeals from an order of the Worker's Compensation Board reversing the referee's determination that claimant's knee injury is compensable. We reverse.

The facts surrounding claimant's injury are essentially undisputed. He was employed as a mechanic. On June 18, 1982, he suffered a knee injury while walking across the shop floor after answering his employer's telephone. He testified that he felt a sudden "snap or a terrific pain" in his left knee and then could not put any weight on it. He stumbled but did not fall to the floor. Claimant was hospitalized that day and, on June 23, underwent corrective surgery. He was determined to have a longitudinally torn left medial meniscus with the medial portion retracted into the intercondylar notch; an arthoscopy with partial resection of the medial meniscus was performed. SAIF, the employer's insurer, denied claimant's worker's compensation claim on the basis that there was insufficient evidence to show that the injury was a result of his work activities.

The evidence at the hearing included reports of two physicians. Claimant's treating physician, Dr. Weinman, reported:

"A meniscus may be torn just by an abnormal step or a twist on a knee. The patient reported that this happened to him while he was walking, while he was on the job. In looking at the meniscus with an arthroscope, it is impossible to tell if there was a pre-existing small tear that was merely enlarged by his activity on the job. If his job includes a lot of squatting down or twisting on his knee, it could contribute to his torn meniscus."

SAIF's medical administrator, Dr. Norton, reported:

"[C]laimant's medical records were reviewed for an opinion regarding the probable cause of his torn meniscus. The review discloses that the claimant developed acute knee pain while walking. There evidently was no prior history of symptoms or injury of any consequence.

"For an acute tear of the medial meniscus to occur in this fashion would be unusual, although not impossible. For a previously torn meniscus to extend enough to displace into the intercondylar notch while walking would be far more

likely. A degenerative fissuring or tearing could occur without a prior incident of accidental injury.

"There appears to be little question that the sudden displacement of the meniscus with locking of the knee occurred at the time of the work incident based on the reported information. The meniscus was still locked into the intercondylar notch at the time of the arthroscopic examination, (an untenable situation) so it is evident that the need for the urgent surgery was occasioned by the incident occurring at work. Under those circumstances it appears that whether or not the condition represented a pre-existing partial tear, or an acute new injury, the result was the same ie. [sic] the claimant's first reported episode of knee locking persisted and required urgent surgery. It was probably happenstance that it occurred at work.

"You asked whether job activities such as kneeling, twisting etc. could cause a meniscus tear. This type of activity could result in an acute meniscus tear, although ordinarily it would be a memorable experience. A degenerative tear could develop gradually, (asymptomatically) and kneeling and twisting activities could contribute over an extended period of time if carried out in a particularly frequent, repetitious, and abusive fashion. The commonest cause of meniscus tears, however, are probably single episodes of trauma. Squatting and rising could produce an acute meniscus tear, but the first pain would be experienced during the commission of the act, not at some remote time. In this claimant's case, if the activity of squatting or working on the knees had caused the meniscus to 'tear' or a previously torn meniscus to 'displace and lock,' the pain and limitation would be experienced immediately upon rising and extending the knee, not after walking a distance. The displacement and locking occurred at the time the acute pain was experienced (while walking)."

The referee found the injury compensable. He analyzed the issue in terms of whether the injury was sufficiently work connected to justify a holding that it arose out of claimant's employment. He found that the injury occurred while claimant was walking across the shop floor after answering the employer's telephone. Relying on *Hubble v. SAIF*, 56 Or App 154, 641 P2d 593, *rev den* 293 Or 103 (1982), in which

we held that a torn medial meniscus sustained by a worker while walking down a straight corridor was compensable, the referee concluded that "when walking is a part of a worker's

job, as it was here, the risk of injury from the walking is a risk of the job."

The Board reversed. It concluded that the case should be analyzed "in terms of whether claimant's fall was caused by idiopathic factors or was truly work related," according to the standard approved in *Phil A. Livesley Co. v. Russ,* 296 Or 25, 672 P2d 337 (1983). Under that standard, an idiopathic fall is not compensable, nor is a fall compensable if it is equally possible that its cause was idiopathic or work related; a truly unexplained fall that occurs on the employer's premises while the employe is performing required duties is compensable if the employe can eliminate idiopathic causes. 296 Or at 30. The Board concluded that "[t]he evidence in this case indicates * * * an equal possibility that the cause of claimant's fall was a pre-existing (i.e., idiopathic) problem or that it was connected to claimant's employment" and that, therefore, claimant had failed to prove that his fall was connected to a risk of his employment. It reversed the order of the referee and ordered SAIF's denial reinstated.

We conclude that the Board erred in applying an "unexplained fall" analysis to this case. That analysis is applicable only when the claimant falls for unknown reasons and injury results from the fall. In such cases, the question is whether there is a sufficient connection between the factors precipitating the unexplained *fall* and the claimant's employment. Because evidence of that causal nexus cannot be directly established, the claimant is required affirmatively to exclude idiopathic factors as the cause of the fall in order to permit an inference that the fall was traceable to some risk of the employment. *Phil A. Livesley Co. v. Russ, supra,* 296 Or at 32.

In applying that analysis, the Board relied primarily on our decision in *Mackey v. SAIF,* 60 Or App 536, 654 P2d 1144 (1983). However, we find that case to be inapposite. There the claimant, a bus driver, injured her low back when her knee buckled and she fell. There was no question but that the fall caused the low-back injury; the issue was whether the cause of her *fall* was work connected. Because the evidence showed no more than that the cause of the fall, her buckling knee, was as likely idiopathic as it was work connected, and because there was no evidence that her knee buckled as a risk

of her employment, we held that she had failed to satisfy her burden of proving work connection. 60 Or App at 538-39.

The issue in this case, as in *Mackey,* is whether the evidence shows that the cause of the collapse of the claimant's leg was work connected. Here, however, the cause of the collapse is known; it was the displacement of claimant's medial meniscus while he was walking across the shop floor after answering his employer's telephone. That is not contested. The evidence from both doctors establishes that walk-

ing can cause an acute medial meniscus tear and displacement. Claimant here is not burdened with establishing the connection to his employment of an unexplained fall that resulted in injury. Rather, the identified event causing the injury was the sudden, unexpected displacement of the medial meniscus, which SAIF agrees should be evaluated under the law governing accidental injury.[1] Because the medical evidence showed that walking was the immediate cause of claimant's acute medial meniscus displacement, the fact that he could not by medical evidence eliminate the possibility that he could have had a pre-existing fissuring or susceptibility to tearing does not defeat his claim. *See Harris v. Albertson's Inc.*, 65 Or App 254, 257, 670 P2d 1059 (1983). Under these circumstances, claimant is not required to disprove all idiopathic causes to permit an inference of work connection; his only burden of proof is to show by a preponderance of the evidence that his injury "arose out of and in the course of employment." *See* ORS 656.005(8)(a).

In determining whether an injury is one arising out of and in the course of employment, we apply a unitary work-correction approach: "[I]s the relationship between the injury and the employment sufficient that the injury should be compensable?" *Rogers v. SAIF*, 289 Or 633, 642, 616 P2d 485 (1980). Under that approach, "course of employment" and "arising out of employment" are components of a single work connection analysis. The accident here occurred during working hours, on the work premises and while claimant was performing a task required by the employer for its benefit—walking back to his work site after answering the employer's telephone. SAIF acknowledges that the "course of employment" component is satisfied.

The focus of our inquiry is on "arising out of employment." To satisfy that part of the test, the employe must show a causal link between the occurrence of the injury and a risk connected with the employment. *Phil A. Livesley Co. v. Russ, supra*, 296 Or at 29. At the time of the injury claimant was walking across the shop floor. The issue, therefore, is narrowed to whether that walking provides the necessary causal link. We conclude that it does.

We note, as did the referee, that this case is factually similar to *Hubble v. SAIF, supra*, where the claimant suffered a torn medial meniscus while walking down a corridor. SAIF argues that *Hubble* is distinquishable on the basis that there the claimant's job required a significant amount of walking and that occasional walking cannot be considered a risk of employment. We disagree. Our holding in *Hubble* did not turn on the fact that the claimant's job required considerable walking, and we do not find the quantum of requisite walking to be the determining factor here. Where a specific work activity, whether isolated or repetitive, is a part of a claimant's job, the risk of injury from that activity is a risk of that job. Here, the evidence showed that walking was a part of claimant's job. The risk of injury from that walking was a risk of the job. Claimant has met his burden of proving that his claim is compensable.

Reversed and remanded with instructions to reinstate the referee's order.

[1] Claimant argues alternatively that his claim is compensable as an occupational disease. Because we determine that he suffered an accidental injury, we do not discuss that contention.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Guadalupe Rivera, Claimant.

RIVERA,
Petitioner,

v.

R & S NURSERY et al,
Respondents.

(82-02812; CA A29073)

Judicial Review from Workers' Compensation Board.

On respondents' petition for reconsideration filed June 14, 1984, and amended petition for reconsideration filed July 16, 1984. Former opinion filed May 9, 1984, 68 Or App 307, 680 P2d 1029 (1984).

Allan M. Muir, Dennis S. Reese, and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland, for petition.

Before Gillette, Presiding Judge, Joseph, Chief Judge,* and Young, Judge.

YOUNG, J.

Petitions for reconsideration allowed; former opinion adhered to.

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* Joseph, C.J., *vice* Van Hoomissen, J.

YOUNG, J.

In this workers' compensation case, respondents have filed a petition and an amended petition for reconsideration of our former opinion. *Rivera v. R & S Nursery,* 68 Or App 307, 680 P2d 1029 (1984). They invite us to reverse ourselves because of our reliance on an exhibit not in evidence. We allow the petitions and adhere to our former opinion.

Respondents are correct that we relied on an exhibit, a signed declaration of forgery, which was marked as an exhibit, but not admitted as evidence. The referee considered the exhibit. His opinion and order states:

> "The carrier's position throughout has been that it will issue claimant another check upon his completion of a notarized declaration of forgery form. *Claimant completed part of the form, but has not had it notarized.*" (Emphasis supplied.)

The Board's order on review addresses the exhibit.

> "The insurer requested claimant fill out the [exhibit] in his handwriting and have it notarized. Upon receipt of the completed form, the insurer indicated it would immediately issue another check payable to claimant * * *. *The document was returned to the insurer, filled out and signed by claimant but not notarized.*" (Emphasis supplied.)

On appeal, one of claimant's assignments of error is

that it was both unreasonable and illegal to require claimant to have his signature notarized. Claimant states in his brief:

> "Claimant provided the carrier with a declaration of forgery (Ex. 24-6, and O&O p. 2), but he was unable to have it notarized in Mexico where he resides."

Reference to the exhibit also appears at several places in respondents' brief. The only difficulty is: The declaration of forgery was not admitted in evidence at the hearing before the referee.

We review the "entire record" *de novo*. ORS 656.298(6). We consider the declaration of forgery, although hearsay, to be relevant and admissible. *See* ORS 656.283(6). It is admitted.[1]

Petition and amended petition for reconsideration allowed; former opinion adhered to.

[1] Petitioner in its amended petition states that, although the declaration of forgery was rejected by the referee as being hearsay, that "[l]ater in the hearing, a copy of the same document was attached to a deposition exhibit and allowed into evidence without objection." That fact, however, does not change the basis of our decision.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jimmy F. Adams, Claimant.

ADAMS,
Petitioner,

v.

GILBERT TOW SERVICE et al,
Respondents.

(81-04335; CA A29201)

Judicial review of the Workers' Compensation Board.

Argued and submited April 11, 1984.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were David A. Hytowitz and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Alan M. Muir, Portland, argued the cause for respondents. With him on the brief were William H. Replogle and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

NEWMAN, J.

Reversed and remanded with instructions to accept claim.

NEWMAN, J.

Claimant appeals an order of the Workers' Compensation Board that upheld the referee's determination that claimant's mycardial infarction is not a compensable injury. We reverse.

Claimant, age 49, was a tow truck driver for employer for approximately three years. He worked six days a week from 8 a.m. to 6 p.m. and every other Sunday. He was also required regularly to respond to night calls. About midday on March 25, 1981, he received a call to tow a wrecked truck from the I-5 freeway in Portland. Under his employer's contract with the police, he had to reach the vehicle within 30 minutes of the call. He was very apprehensive about freeway tows because of the heavy, high speed traffic. On several occasions he was nearly hit, and once a fellow employee was nearly killed on a freeway tow. Claimant's fear often disturbed his sleep.

While claimant was driving northward on I-5 to the scene of the wreck, another vehicle struck his tow truck and broke its turn signal and running lights. He began to suffer chest pains and to sweat. His arms felt very tired. Although the pain became worse, claimant went to the scene of the wreck. The police officer at the scene told him to hook the vehicle up and remove it. He was excited and nervous, in part because the officer was not blocking traffic. Claimant let the sling down, crawled under the vehicle's side and hooked up the towing lights. Claimant's chest was hurting and his feet "wouldn't work right."

After leaving the freeway, claimant felt nauseous and stopped his truck on a city street. He got out of the truck and lay down at the side of the road. He then attempted to drive the truck but could not, because his "feet wouldn't work." He radioed his company, got out of the truck and lay down again. A friend saw him and took him to a medical clinic, where a doctor diagnosed a myocardial infarction. Claimant was hospitalized for ten days. He did not return to work.

Claimant suffered from artheriosclerosis and hypertension. He did not regularly take medication prescribed for control of his blood pressure. Two family members had suffered from hypertension. Claimant had smoked cigarettes since age 19, averaging a pack a day. He was smoking half a

pack a day at the time of the infarction. Nine days before, he was treated at a hospital for nausea, headache and lightheadedness. The insurer denied his claim, stating that the attack "is not a result of nor arose out of your job and occupation."

Claimant must establish legal and medical causation by a preponderance of the evidence. *Bush v. SAIF,* 68 Or App 230, 680 P2d 1010 (1984); *Harris v. Farmers' Co-op Creamery,* 53 Or App 618, 632 P2d 1299, *rev den* 291 Or 893 (1981). Claimant does not argue that the stress of his work caused his underlying heart disease but that it caused the myocardial infarction. Legal causation here is clear. Claimant suffered physical and emotional stress in carrying out his job. *See Batdorf v. SAIF,* 54 Or App 496, 635 P2d 396 (1981). The issue is medical causation: whether the stress of claimant's work was, within the range of reasonable medical probability, a material contributing cause of his myocardial infarction.

At the hearing two cardiologists testified. Although neither believed that claimant's cardiovascular disease was caused by his work, they disagreed whether the stress of his

work was a material contributing cause of claimant's myocardial infarction. Dr. Wysham, who had examined claimant, stated that acute physical or emotional stress can cause a myocardial infarction in either of two ways. In his opinion, temporary stress can increase blood pressure and pulse rate, leading to insufficient oxygen and to an infarction. Alternatively, in his opinion, stress can increase blood pressure and rupture plaque, which can clog an artery, causing an attack. Dr. Wysham relied in part on a 1977 Special Report of The Committee on Stress, Strain and Heart Disease of the American Heart Association, which concluded:

> "A single isolated episode of stress (physical or emotional) in individuals rendered susceptible because of underlying heart disease, if of sufficient intensity and duration, appears capable of eliciting adverse responses which might trigger or hasten certain cardiac lesions and dysfunctions. These may include angina pectoris, a cardia dysrhythmia, acute congestive failure or possibly myocardial infarction."

Dr. Wysham considered the stress involved in claimant's work on the day of the attack and concluded that it was "a major contributing factor" in the attack.

In Dr. Trelstad's opinion, the myocardial infarction was "basically a random event." In the light of claimant's medical history, his smoking, his family history and his failure to take medication, Dr. Trelstad found it coincidental that the myocardial infarction happened while claimant was at work. He acknowledged that the issue of whether stress can contribute to a myocardial infarction is controversial. He believed, however, that the Special Report's language was a "real hedge." He considered the infarction as not work-related, because the stress on claimant that day was "of very short duration" and it "did not seem as though the pressure on [claimant] at that time was a lot different than he had previously experienced and had no problems with."

The referee found:

> "The medical evidence, in my view, is in equipoise. While Dr. Wysham has more experience than Dr. Trelstad and has the additional advantage of having actually examined and spoken to claimant, Dr. Trelstad's opinion appears to be in harmony with the Special Report * * * relied upon by both of these gentlemen in their testimony. Accordingly, I reluctantly conclude that claimant has failed to meet his burden of proof."

We disagree. We find Dr. Wysham's testimony more convincing. Dr. Trelstad acknowledged that he had found stress a material contributing cause of myocardial infarctions in other cases. He thought that here stress was not a contributing cause because of claimant's medical history and habits and because he did not think claimant experienced unusual stress. The evidence shows, however, that claimant, at the time of the infarction, was under severe stress and, while under that stress, was required to perform a dangerous job quickly. There was ample evidence that the stress claimant experienced was not of "very short duration" or common.

We also disagree with the Board that an "equally plausible theory" was that claimant's myocardial infarction was caused by the "natural progression of his pre-existing cardiovascular disease." Given the evidence of events preceding and at the time of claimant's attack, and Dr. Wysham's

testimony, we find it improbable that the myocardial infarction was a random occurrence. The stress of claimant's job was a material contributing cause of the infarction.

Reversed and remanded to the Board with instructions to accept the claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bert G. Harr, Claimant.

ASC CONTRACTORS,
Petitioner,
v.
BERT G. HARR,
Respondent.

(82-03306; CA A30063)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 29, 1984.

LaVonne Reimer, Portland, argued the cause for petitioner. On the brief were Michael G. Bostwick and Lindsay, Hart, Neil & Weigler, Portland.

James S. Coon, Portland, argued the cause for respondent. With him on the brief was Welch, Bruun and Green, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

ASC Contractors, the employer in this workers' compensation case, seeks reversal of an order on review of the Workers' Compensation Board, which found claimant's claim for carpal tunnel syndrome to be compensable. We affirm.[1]

The employer denied responsiblity, because it asserted that claimant had experienced symptoms of carpal tunnel syndrome before he began to work for employer. Claimant admits to having suffered intermittent numbness in

[1] The employer also appeals the award of attorney fees. We find no error in the award.

the first three fingers of each of his hands. He states that he experienced those symptoms for four years before he started working for employer and that they were worse when he was driving, at night and during the spring and fall seasons. However, he had been asymptomatic for several months before his employment, and there is no record of his having received medical treatment at any time for the condition, or that there had been any diagnosis of the condition.

The medical evidence indicates that, although claimant's employment was the major contributing cause of the "relapse" of what the doctors assumed was a preexisting carpal tunnel syndrome and caused that condition to become symptomatic, it did not materially worsen the underlying condition. The facts here are indistinguishable from those which we found to support compensability in *Wheeler v. Boise Cascade,* 66 Or App 620, 675 P2d 499, *rev allowed* 296 Or 829 (1984). Although claimant's employment did not worsen his underlying preexisting condition, it did cause that condition, which had not required previous medical care, to become symptomatic and to require medical treatment. Therefore, the claim is compensable. *Hutcheson v. Weyerhaeuser,* 288 Or 51, 602 P2d 268 (1979); *Wheeler v. Boise Cascade, supra.*

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Clarence Poole, Claimant.

POOLE,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(81-08408; CA A28966)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 11, 1984.

Karol Wyatt Kersh, Salem, argued the cause for petitioner. On the brief were Steven R. Huff, and Karol Wyatt Kersh & Associates, P.C., Salem.

Darrell E. Bewley, Appellate Counsel, State Accident Insurance Fund Corporation, Salem, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

The main issue in this workers' compensation case is whether the carrier is responsible for payment of claimant's bills for chiropractic treatment. The Workers' Compensation Board concluded that the condition for which claimant received the treatment did not result from his compensable injury and so the carrier is not responsible. We affirm.

Claimant, a draftsman, compensably injured his back in March, 1978, when he lifted some desk drawers. In August, 1980, he received an award of 20 percent permanent partial disability. Shortly before that, claimant had begun treatment with a chiropractor, Dr. Nickila, who submitted his bills to SAIF. SAIF paid until March, 1981, when it requested information from Dr. Nickila about the relationship between the treatment and claimant's on-the-job injury. Dr. Nickila did not respond, and SAIF held the bills without paying them and without notifying claimant. In March, 1982, Dr. Nickila finally responded to SAIF but he focused on his own legal conclusion regarding the binding effect of the 1980 award. Finally, at the hearing on May 5, 1982, SAIF denied responsibility for the chiropractic treatment.[1] Pursuant to ORS 656.262, claimant requested a penalty and attorney fees for SAIF's unreasonable delay in denying.

The first issue is the relationship between Dr. Nickila's treatment and the 1978 injury. Under ORS 656.245(1),

> "[f]or every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability. * * * The duty to provide such medical services continues for the life of the worker."

SAIF contends that claimant's chiropractic treatments are for a degenerative disease unrelated to the 1978 injury. As with compensability in general, claimant has the burden of proving that the condition for which he receives medical services was caused by his compensable injury and that the treatment is

reasonable and necessary. *SAIF v. Forrest,* 68 Or App 312, 680 P2d 1031 (1984); *see also McGarry v. SAIF,* 24 Or App 883, 547 P2d 654 (1976). We conclude that claimant has not met his burden.

After the original injury, claimant first saw Dr. Drips, his family physician, whose impression was "acute lumbosacral strain, superimposed on pattern of prior low back strain." Later that year claimant was hospitalized, and Dr. Drips' diagnosis was "chronic relapsing lumbar strain." Dr. Tiley, an orthopedic surgeon, began treating claimant. He noted early degenerative disc disease with "chronic positional strain," explaining that claimant's drafting work caused

[1] Claimant does not contend that SAIF is foreclosed from denying responsibility to pay the medical bills because of the payments of the earlier bills.

chronic tension in the spinal support musculature. In mid-1979 an examiner at the Callahan Center also diagnosed chronic lumbar back strain.

Those examiners who noted the degenerative disease did not imply that it was in any way caused by claimant's employment. While claimant was at the Callahan Center Dr. Loeb, a psychologist, concluded that there was a psychological element in claimant's condition. In making the award of permanent partial disability in 1980, the referee found that claimant had a "conversion reaction" precipitated by his injury by which he was incapacitated to some extent by his focus on a strain which normally would have resolved over time. The referee also noted that "the degenerative changes are a result of age."

Claimant relies on the reports and testimony of Dr. Nickila. In a letter to claimant's attorney, Dr. Nickila stated conclusorily that his treatments were "necessary to treat the partial permanent residuals from the 1978 work injury." At the hearing he agreed that claimant has a degenerative back condition, but said that the compensable injury affected his ligaments, creating a propensity of "resubluxation" of his joints, which in turn creates nerve pressure. Although he stated that claimant had some disc problems, he felt that the injury was the cause of his sciatica.

Controverting Dr. Nickila's conclusions are the reports of Dr. Fechtel and Dr. Tiley. In December, 1980, Dr. Fechtel examined claimant for SAIF. He noted:

> "* * * Subjective complaints far outweigh objective orthopaedic findings. * * * Again, pain complaints without significant muscle spasm, or neuro-tenderness in the expected regions further suggests that there is not a mechanical problem promoting the patient's pain problem. * * *
>
> "The present complaints do not correlate with the mechanism of injury. Mechanism of injury is suggestive of acute lumbar sprain which should have resolved within two to three, or possibly four months. * * *"

In March, 1981, after x-rays, Dr. Fechtel said in response to SAIF's inquiry:

> "This examiner reviewed this patient in orthopaedic consultation on Oct. 16, 1980. At that time it was my opinion that Mr. Poole did not present any biomechanical problem in the lumber spine and probably had significant psychogenic expansion of symptoms. X-rays taken at the time by Salem Radiology Consultants suggested some spondylosis deformens in the lumber spine. This would suggest a chronic progressive disorder in the lumbar spine. This patient very well may seek further manipulative treatments, these will probably alleviate some low back discomfort. However, the need for treatment would be consistent with the progressive underlying disorder and not a strain type injury in the lumber spine some years prior.
>
> "In summary need for current treatment is not related to the compensable injury of 28 March 1978."

In April, 1982, Dr. Tiley reported:

"X-rays of the lumbosacral spine show some degenerative changes in a moderate amount and this seems to be perhaps a little bit more than was seen on a previous film. Again we counselled him with regard to back care. I certainly don't feel that any major treatment is necessary. He has disc degeneration of the low back but his symptoms are out of proportion to the amount of dysfunction that he manifests. * * *"

He wrote to SAIF:

"* * * Mr. Poole continues to receive chiropractic care for his degenerative disc disease which gives him temporary palliative symptomatic relief but is in no way curative. As can be seen in our clinic note, x-rays have shown progression of his degenerative disc disease and this is to be expected and natural and unrelated to any specific injury. * * *"

We are persuaded by the opinions of Dr. Fechtel and Dr. Tiley that claimant's chiropractic services are not necessitated by any physical condition resulting from the 1978 injury. Although there is evidence that at least some of claimant's symptoms are a result of the "conversion reaction" noted by the referee in 1980, claimant has not demonstrated that that condition necessitates this treatment. We agree with the Board that SAIF is not responsible for Dr. Nickila's bills.

Claimant argues that the Board's opinion is inconsistent with the 1980 order awarding 20 percent permanent partial disability, amounting to a "backdoor method of relitigating initial compensation." We do not find an inconsistency between the referee's 1980 order and the Board's conclusion that claimant's current treatment is not necessitated by his 1978 strain injury.

Claimant also requests penalties and attorney fees under ORS 656.262(10) for SAIF's delay in denying the claim. Assuming *arguendo* that the chiropractor's request for payment of medical benefits does constitute a "claim," ORS 656.005(7), 656.005(9), and that SAIF was thus required to give written notice of acceptance or denial within 60 days, ORS 656.262(6), under ORS 656.262(10) penalties can only be assessed on "amounts then due." Unlike the case of disability benefits, there is no duty to pay interim compensation for medical services pending acceptance or denial, ORS 656.262(6), and we have concluded that claimant was not entitled to payment of those bills. There were no "amounts then due," and no penalty can be assessed under ORS 656.262(10). *See EBI Companies v. Thomas,* 66 Or App 105, 111, 672 P2d 1241 (1983); *see also Kosanke v. SAIF,* 41 Or App 17, 596 P2d 1013 (1979).

Claimant also requests attorney fees pursuant to ORS 656.382 on the ground that SAIF "unreasonably resisted the payment of compensation." Even if SAIF was unreasonable in its delayed denial, under the circumstances it was not unreasonable in refusing to pay Dr. Nickila's bills.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Margaret Maarefi, Claimant.

MAAREFI,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent.

(82-00194; CA A29581)

Judicial review of the Workers' Compensation Board.

Argued and submitted April 11, 1984.

William H. Skalak, Milwaukie, argued and cause and filed the brief for petitioner.

Darrell E. Bewley, Assistant Attorney General, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

WARDEN, J.

Affirmed.

WARDEN, J.

Claimant appeals from a decision of the Workers' Compensation Board that affirmed the referee's award of five percent unscheduled permanent partial disability and found that she had become medically stationary by October 16, 1981. Claimant also appeals the Board's determination that she did not file a valid aggravation claim after her claim was closed. We affirm.

Claimant was injured January 27, 1981, when she slipped and fell while working as a beautician. She went home that day but returned to work the next day and worked for a week and a half before seeing her family physician, Dr. Stevens, who approved her seeing a chiropractor. The chiropractor, Dr. Erdman, diagnosed her condition as a lumbar sprain with radiculitis and paravertebral muscle spasm and cervical strain with accompanying headache. Claimant was then referred by Dr. Stevens to an orthopedic surgeon, Dr. Vigeland, who diagnosed her condition similarly and treated her until March, 1981. In March, Dr. Vigeland indicated that she probably would have no permanent impairment and suggested that she return in two to three weeks for consideration of closure. He then released her to return to work. On March 23, 1981, she resumed part-time work.

In July she was evaluated for the employer by Dr.

Pasquesi, whose opinion was that she had reached a stationary stage but that she had an impairment equivalent to five percent of a whole person and should avoid repetitive bending, stooping and lifting. Dr. Stevens then referred claimant to Dr. Miller, a neurosurgeon, who reported in July, 1981, that he could find no neurological abnormalities. After seeing claimant for several months, Dr. Miller reported on October 19 that she was medically stationary, that she suffered from cervical and lumbosacral strain and that physiotherapy was no longer needed. The Evaluation Division of the Workers' Compensation Department declared claimant medically stationary as of October 16, 1981, and closed her claim by Determination Order on November 12, 1981, with no award for permanent partial disability.

Claimant had indicated to Dr. Miller her unhappiness with his conclusions, and in December, 1981, she began seeing Dr. Berovic, a chiropractor, on the advice of a friend at

work. Shortly thereafter, on January 7, 1982, claimant initiated the procedure for review of the Determination Order by requesting a hearing. In an Opinion and Order dated December 29, 1982, the referee approved the closure of her claim but found that she had suffered some residual impairment and awarded her five percent unscheduled permanent partial disability. The Board affirmed.

Claimant's first assignment of error is that the evidence demonstrates a significantly greater impairment than is reflected in the five percent unscheduled permanent partial disability award. *De novo* review of the record convinces us that that assignment is not well taken.

Claimant's second and third assignments of error are that her claim was improperly closed by the November 12, 1981, Determination Order and that the Workers' Compensation Board should have ruled that Dr. Berovic's letters and reports between January 18, 1982, and August 2, 1982, raised a valid claim of aggravation, justifying the reopening of her claim. She relies on Dr. Berovic's letters and reports to support both assignments of error. We conclude that those letters and reports fail to establish either that claimant was not medically stationary at the time her claim was closed or a valid aggravation claim.

The term "medically stationary" is defined in ORS 656.005(17):

> "Medically stationary means that no further material improvement would reasonably be expected from medical treatment, or the passage of time."

Although Dr. Berovic's letter of August 2, 1982, states that "I do not feel Ms. Maarefi was medically stationary in December, 1981," we conclude that the Evaluation Division had sufficient evidence to close the claim effective October 16, 1981, and that the Division's determination that she had become medically stationary was borne out by the later development of claimant's condition. The sense in which Dr. Berovic used the term "medically stationary" differs from the sense used by the statute. Dr. Berovic's meaning is suggested by the statement

in his letter of May 19, 1982, that "the patient in my opinion would be unable to continue working as a hairdresser without treatment" and by the statement in his letter of April 29, 1982,

that "[a]s a result of her occupational activity, the patient has experienced remissions and exacerbations of symptoms since beginning treatment with me." By "medically stationary," Dr. Berovic apparently means either a lack of variation in one's medical condition or a lack of need for any continuing medical treatment.

Neither meaning is consistent with the statute. The statutory definition is that "no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). One whose medical condition fluctuates may still be medically stationary in this sense. Moreover, ORS 656.245 requires the inference that one who has been declared permanently disabled in any degree can be medically stationary within the meaning of ORS 656.005(17) and still require continuing treatment:

> "Medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability. * * * The duty to provide such services continues for the life of the worker."

Claimant is entitled under ORS 656.245 to full compensation for the cost of the treatments she needs to keep working. *Wait v. Montgomery Ward, Inc.*, 10 Or App 333, 338, 499 P2d 1340, *rev den* (1972).

Dr. Berovic's letters and reports do indicate that claimant's condition fluctuated after her claim was closed. His letters also indicate, and we accept, that claimant requires continuing chiropractic treatments and that her condition improved to some extent after her claim was closed.[1] However, that her condition improved does not establish that as of October 16, 1981, "no further material improvement would reasonably be expected" in that condition. Dr. Berovic's description of claimant's condition is not materially different from that described in Dr. Miller's letter of October 19, 1981. Both doctors noted claimant's complaints of pain and muscle

spasms in her neck and low back, and both doctors noted her inability to flex her back fully without pain in the midportion of her low back. Claimant was working the same number of hours per week on June 30, 1982, that she worked on October 16, 1981, and Dr. Berovic does not indicate that claimant's ability to withstand the conditions of her job had either worsened or improved.

Dr. Berovic's failure to assert that claimant's condition worsened after her claim was closed and his assertion that

[1] According to his letter of August 2, 1982, his opinion that claimant was not medically stationary in December, 1981, was based "on the patient's physical position on initial examination and [her] objective improvement substantiated by reexaminations up to June 30, 1982. * * * We have steadily seen a resolution of abnormal findings and presently have only a positive leg raise."

instead claimant's condition had improved require us to reject claimant's argument that Dr. Berovic's letters and reports raised a valid claim of aggravation justifying the reopening of her claim.[2] Claimant reads ORS 656.273(3) in isolation from the rest of the section and claims that the statute does not require a statement by a physician that the claimant's condition has worsened, but need only indicate "a need for further medical services or additional compensation * * *." Claimant ignores the more general description of a claim for aggravation in ORS 656.273:

> "(1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury.
>
> "* * * * *
>
> "(3) A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation."

Previous opinions of this court have frequently noted the requirement that a claimant prove a worsened condition to support a claim for aggravation. *See, e.g., Trevino v. SAIF,* 66 Or App 410, 673 P2d 1389 (1984); *Wetzel v. Goodwin Brothers,* 50 Or App 101, 622 P2d 750 (1981); *Anderson v. West Union Village Square,* 43 Or App 295, 602 P2d 1092 (1979); 44 Or App 685, 607 P2d 196 (1980); *Dinnocenzo v. SAIF,* 18 Or App 63, 523 P2d 1280 (1974). Dr. Berovic's July 15, 1982, report does indicate that "she will likely have exacerbations of symptoms in the future." If claimant's symptoms do "exacerbate," she

may be entitled to have her claim reopened under ORS 656.273 or to additional medical services under ORS 656.245. That "she will likely have exacerbation of symptoms in the future," however, does not state a present worsening requiring further medical service or additional compensation and, therefore, is not a claim for aggravation.

Affirmed.

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[2] The possibility that claimant's condition worsened between the closure of her claim and her first visit to Dr. Berovic is negated by her testimony that her medical condition on December 15, 1981, was essentially identical to her condition on October 16, 1981.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Maxine P. Robinson, Claimant.

ROBINSON,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent.

(81-10158 & 82-05121; CA A29585)

Judicial review of the Workers' Compensation Board.

Argued and submitted April 11, 1984.

Christopher D. Moore, Eugene, argued the cause for petitioner. With him on the brief were Evohl F. Malagon and Malagon & Associates, Eugene.

Donna Parton Garaventa, Assistant Attorney General, argued the cause for respondent. With her on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

WARDEN, J.

Reversed and remanded for determination of compensability.

WARDEN, J.

Claimant appeals from an order of the Workers' Compensation Board that reversed the referee's decision that her claim was timely filed and compensable. The Board found that the claim was not timely filed and therefore did not consider the merits of her claim. We reverse on the timeliness issue and remand to the Board for consideration of compensability.

Claimant began work as a salesperson for Struther's Furniture in March, 1975. In the spring of 1978, she began to experience chronic fatigue. She continued working for Struther's until she was laid off in November, 1978. In early 1979, she began working for Adamson's Furniture. Her fatigue continued, and she also began to have "dizzy spells." Because of those health problems, she terminated her employment with Adamson's after a few months. She filed this claim against both Struther's and Adamson's for worker's compensation benefits on September 24, 1981.[1] SAIF asserts in its brief that Struther's was bankrupt and out of business at that time.

[1] SAIF had insured both Struther's and Adamson's. It denied the claim on behalf of both. The referee reversed Struther's denial and affirmed Adamson's. SAIF requested Board review of the referee's order as to Struthers; claimant did not request review of the order affirming Adamson's denial.

Claimant's theory of compensability is that she has an occupational disease caused by her becoming sensitized to certain substances to which she was exposed in her work environment.[2]

We determine only the threshold issue of whether claimant's claim was timely filed. ORS 656.807 provides, in part:

> "[A]ll occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer within five years after the last exposure in employment subject to the

> Workers' Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease whichever is later."

The date of claimant's disability is mid-1979, when she terminated her employment with Adamson's, her second employer. The parties agree that the date when she was "informed by a physician that [she was] suffering from an occupational disease" occurred later, although they disagree as to which of two dates applies.

To make the limitations statute commence to run, a claimant must be told in clear language that the condition arose out of the employment. *Johnson v. SAIF*, 53 Or App 627, 631-33, 633 P2d 17 (1981), *modified* 55 Or App 638, 639 P2d 137, *rev den* 293 Or 103 (1982); *Templeton v. Pope and Talbot, Inc.*, 7 Or App 119, 120-21, 490 P2d 205 (1971). SAIF argues that statements of claimant's physician, Dr. Gambee, on June 30, 1982, rose to that level. Dr. Gambee stated:

> "On June 30, 1980, after we had done some testing on [claimant], I discussed with her the fact that she had a higher than normal degree of sensitivity to certain chemicals in our environment. I also explained to her that her working environment contained an even higher than normal concentration of these substances. Because of these conditions, I felt that she might have difficulty overcoming some of her health complaints if she continued to work in that environment."

Claimant argues that she was not told of the work connection to her disease with a sufficient degree of precision until March 12, 1981, when Dr. Gambee wrote to her attorney:

> "Since the work environment that [claimant] described to me, consisting of synthetic fabrics, furniture using particle board, poorly ventilated, no air conditioning, and uncomfortably warm, would all contribute to the gassing out process, then I would think that her environment could well be one in which one would become sensitized to chemicals."

---

[2] Claimant's contends that particular substances known to be present in synthetic fibers, including phenol, hydrocarbon and formaldehyde, were released in large quantities into her work environment, especially when new furniture began a "gassing out" process upon being uncrated in the store showroom. Although claimant acknowledges that those substances are ubiquitous in the general environment, her hypothesis is that the unusually high concentration of them in her work place, coupled with poor ventilation, caused her sensitization and resultant health problems. We express no opinion on the merits of this claim.

If April 30, 1980, is deemed to be the date claimant received notice that her disease was occupational in nature, her claim was not filed until more than nine months after the 180 day limitation. If March 12, 1981, is deemed to be that

date, her claim was filed 16 days after the limitation period. SAIF's primary argument is that, regardless of which date applies, the claim is void under the literal language of ORS 656.807(1) because it was not filed within the statutory period. We disagree.

ORS 656.807(1) cannot be viewed in isolation, but must be considered in the context of the statutory scheme. ORS 656.807(5) states: "The procedure for processing occupational disease claims shall be the same as provided for accidental injuries under ORS 656.001 to 656.794." Under ORS 656.265(4)(a), one of the referenced statutes, an injured worker's failure to provide timely notice is excused if: "The employer had knowledge of the injury or death, or the insurer or self-insured employer *has not been prejudiced by failure to receive the notice* * * *." (Emphasis supplied.) That exception was extended to occupational disease claimants by the Supreme Court in *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 347, 605 P2d 1175 (1980). *See also Gronquist v. SAIF*, 25 Or App 27, 31, 547 P2d 1374, *rev den* (1976). Accordingly, SAIF may not prevail on a timeliness defense under ORS 656.807(1) unless it has been prejudiced by claimant's late filing.

The burden of proving prejudice from an untimely notice is on SAIF. *See Inkley v. Forest Fiber Products Co., supra*, 288 Or at 348; *Satterfield v. Compensation Dept.*, 1 Or App 524, 465 P2d 239 (1970). To bar a claim, that prejudice must have occurred *after* the 180 days to which a worker is statutorily entitled. *McNett v. Roy-Ladd Const. Co.*, 46 Or App 601, 605, 613 P2d 47, *rev den* 289 Or 588 (1980). In this case, SAIF's claim of prejudice is that, because the employer was bankrupt and out of business by the time claimant filed her claim, it had no opportunity to perform chemical density tests at the alleged exposure site to compare to nonemployment related exposures or "to otherwise adequately investigate the claim." We are not persuaded.

The record is silent as to the time of the employer's bankruptcy; even assuming, without deciding, that Dr. Gambee's conversation with claimant in April, 1980, started the running of the statutory limitation period, SAIF has failed to show that Struther's went out of business more than 180

days after that date.[3] It has not shown that it was otherwise hampered in its investigation by claimant's delay in filing her claim, and we find nothing in the record from which to infer prejudice from the passage of time alone. *See Satterfield v. Compensation Dept., supra*, 1 Or App at 528. We hold that SAIF has failed to carry its burden of proving prejudice, and we reverse the Board's order holding that claimant's occupa-

tional disease claim was barred for lack of timeliness. Because the Board did not consider the merits of the claim, we remand for consideration of compensability.

Reversed and remanded to the Board for determination of compensability.

[3] Because SAIF has not shown any specific prejudicial event, we need not decide which of Dr. Gambee's two reported communications with claimant commenced the running of the statutory period.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Zoi Sarantis, Claimant.

SARANTIS,
Petitioner,
v.
SHERATON CORP.,
Respondent.

(81-08881; CA A29235)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 13, 1984.

Richard A. Sly, Portland, argued the cause for petitioner. With him on the brief was Bloom, Marandas & Sly, Portland.

Allan M. Muir, Portland, argued the cause for respondent. With him on the brief were Ridgway K. Foley, Jr., William H. Replogle and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Reversed; referee's order reinstated.

GILLETTE, P. J.

Claimant, an immigrant Greek woman in her early 50's, injured her lower back while working as a maid for respondent's Lloyd Center Sheraton Hotel in Portland. She has been in constant pain since the injury, and a referee awarded her permanent total disability. The Workers' Compensation Board reduced the award to 70 percent permanent partial disability, finding that claimant's refusal to undergo a laminectomy was unreasonable. On *de novo* review, we reverse and remand.

Although the statutes do not explicitly provide that a permanent disability award should be reduced if the claimant unreasonably refuses to submit to recommended treatment, such a reduction is implicit in Oregon's Workers' Compensation Law. The reason is that, to the extent that the rejected treatment would improve the claimant's condition, the dis-

ability is attributable to the claimant's unreasonable refusal rather than to the employment. *Nelson v. EBI Companies,* 296 Or 246, 674 P2d 596 (1984); *Grant v. State Industrial Acc. Com.,* 102 Or 26, 41-42, 201 P 438 (1921); *Clemons v. Roseburg Lumber Co.,* 34 Or App 135, 138-39 n 2, 578 P2d 429 (1978); 1 Larson, Workmen's Compensation Law, § 13.22.

The crucial issue in this case is the reasonableness of claimant's refusal. This is an appropriate occasion to explain further the criteria by which we determine reasonableness in cases of this sort. We have previously said that the test for reasonableness is "whether, if compensation were not an issue, an ordinarily prudent and reasonable person would submit to the recommended treatment." The relevant factors include "the worker's present physical and psychological condition, the degree of pain accompanying and following his treatment, the risks posed by the treatment, and the likelihood that it would significantly reduce the worker's disability." *Clemons v. Roseburg Lumber Co., supra,* 34 Or App at 139. The employer has the burden of showing a refusal to be unreasonable. *Nelson v. EBI Companies, supra,* 296 Or at 252.

There usually is not just one "correct" decision about the advisability of a course of treatment. Workers have the right to decide whether to undergo treatment, and we determine only whether a decision is reasonable. The law does not force all workers into the same mold. It provides them with

discretion to make their own decisions about their own lives but protects employers from paying for unreasonable exercises of that discretion.

> "[I]t would be surprising to find a provision in our statute giving arbitrary power to the commission, or making the workman's right of refusal dependent upon medical opinion alone, and entirely ignoring the viewpoint of the workman who is the only one who must take whatever risk is involved, must endure whatever suffering is to be borne, and must accept whatever ill effects may result from the operation." *Grant v. State Industrial Acc. Com., supra,* 102 Or at 44.

The question, then, is how we as factfinders determine whether a particular decision is within the range of discretion the law grants the worker. One way to answer it is by stating what we do *not* do: We do not determine whether we would ourselves choose to undergo the treatment, nor whether a different worker would do so. Rather, to find the refusal unreasonable, we must find that *no* reasonable person would refuse: "[A]n ordinarily prudent and reasonable person *would submit* to the recommended treatment." *Clemons v. Roseburg Lumber Co., supra,* 32 Or App at 139. (Emphasis supplied.) The test is objective, which means that we do not decide whether this particular claimant's *reasons* for refusal are reasonable; rather, we decide whether the *decision* itself is within the range of decisions reasonable people might make.

Our evaluation of a claimant's decision by an objective standard of reasonableness has certain consequences. First, we apply the test of reasonableness to the situation as the claimant knew it; medical or other information of which the claimant was unaware or was unable to appreciate is

irrelevant in determining whether the decision was reasonable.[1] Second, the claimant's personal characteristics, including his or her physical and psychological condition, are relevant only to the extent that they affect the claimant's ability to undergo the treatment and achieve a successful result. Third, external influences or irrational fears, no matter how genuine, do not excuse an otherwise unreasonable refusal. Finally, we necessarily consider the risks and pain of the

treatment from the claimant's, not the physician's, perspective. There is a significant distinction between the detached analysis of a surgeon who performs many operations and the interested analysis of a worker who must decide whether to undergo *this* operation. *Clemons v. Roseburg Lumber Co., supra,* 32 Or App at 139-140.

Previous decisions and other authority provide examples of how to apply this test. Larson states, almost as an axiom, that, when there is a real risk involved in the proposed medical treatment, a claimant cannot be forced to undergo that risk at the peril of losing compensation. 1 Larson, Workmen's Compensation Law, § 13.12 at 3-410 to 3-434. That statement is consistent with previous Oregon cases, which have consistently upheld compensation despite refusal of medical treatment that involved a significant risk. *See Grant v. State Industrial Acc. Com., supra* (refusal to undergo a knee operation that involved an apparently small risk of a permanently stiff knee); *Reef v. Willamette Industries,* 65 Or App 366, 671 P2d 1197 (1983) (refusal to undergo a myelogram); *Gainer v. SAIF,* 50 Or App 457, 623 P2d 1093 (1981) (refusal to undergo myelogram and resulting probable laminectomy); *Clemons v. Roseburg Lumber Co., supra,* 34 Or App at 140 (refusal to undergo relatively painful transaxillary rib resection which required general anesthesia); *Finley v. SAIF,* 34 Or App 129, 578 P2d 432 (1978) (refusal to undergo myelogram). We now apply our test to this case.

Claimant came to this country in the late 1970's. She has a third grade education and speaks only Greek. Until her injury, she had never been in a hospital or seen a doctor. She has done physical labor since she was a child, hoeing in the fields before her marriage at age 16 and working in a variety of factory jobs in Greece, Germany and this country before taking her position with respondent. She was injured while folding up a new sleeper sofa after making the bed; the mattress was tight and she strained her back trying to force the sofa together.

After her injury, claimant was taken to a hospital emergency room, where she was treated and referred to an orthopedist. She saw the orthopedist regularly for a year, cooperating readily with his recommended treatment. During this period, she was evaluated by Orthopaedic Consultants

[1] Of course, if the issue is a continuing refusal to undergo treatment, information which the claimant learns in the course of a hearing, or otherwise after the original refusal, may be relevant to whether the refusal continues to be reasonable.

and, later, by a neurologist; they generally concurred in her orthopedist's conservative treatment. About a year after the injury, she moved to another part of the city. Her vocational rehabilitation counselor, who apparently disapproved of her orthopedist's approach, sent her to a different orthopedist closer to her new home. The new orthopedist referred her to Dr. Parsons, a neurosurgeon, who performed a myelogram, which revealed a loss of nerve root sleeve and a probable extruded disk in the lower lumbar region. Parsons recommended a laminectomy on the right side, stating that it provided a 75 percent chance of improvement and could make claimant able to return to work. After consulting with her family, claimant refused the operation.

After claimant's refusal and another evaluation by Orthopaedic Consultants, the department issued a determination order granting her 40 percent unscheduled permanent partial disability. The referee awarded her permanent total disability, which the Board reduced to 70 percent permanent partial disability because of her refusal of the operation. Although respondent makes a *pro forma* argument otherwise, we find that the only possible basis for an award of less than permanent total disability is that her refusal to undergo the operation was unreasonable.

Claimant refused the operation because of her fear of the risks involved.[2] As she put it, she did not want to spend the rest of her life in a wheelchair or on her knees praying. She knew of other people who had had operations and had ended up in wheelchairs, and she was afraid of joining them. She had cooperated with her physicians until that time and had been eager to change to a new physician who would pursue more aggressive measures because of her frustration over her lack of progress. All of her cooperation with her physicians, however, had produced no positive results. She felt increasingly hopeless about improvement, and her self-esteem had fallen drastically because of her inability to work, either inside or outside

the home. Her family discussed the matter and strongly urged against the operation.[3]

Before the laminectomy issue, claimant was a totally cooperative patient who complied with all treatments and recommendations of her physician. When conservative methods did not work, she agreed to and underwent a myelogram. Her only refusal, therefore, has been of the laminectomy. Claimant's knowledge of the risks inherent in that operation is unclear from this record. She does not speak English, her husband's English is poor, and there was not always an interpreter available to her. Therefore, it is very difficult to

[2] She also stated that she was afraid of "the knife." In the context of her testimony we believe that her fear of the knife was partly a resistance to all surgery and partly another way of expressing her fear that the operation might cause permanent damage.

[3] Claimant's husband testified that, when he talked with their son (who is still in Greece) about the situation, the son threatened to kill his father if claimant ended up in a wheelchair because of the operation.

determine what information she actually obtained from the doctor. Although Dr. Parsons stated in a letter that he told her that there was a 75 percent chance of improvement and that the risks were not as great as she feared, he did not state what he told her the actual risks were. Claimant and her husband testified that they understood the doctor to say that there was a 50 to 75 percent chance of improvement but that it would be fate if claimant ended up in a wheelchair and that she might end up in a wheelchair without the operation. When claimant decided not to have the operation, she knew that there was a good possibility that it would improve her condition. She also knew that there was a possibility that it would make her worse and that there was a possibility that she would get worse without it.

We have noted in previous cases that a myelogram, a less serious procedure than a laminectomy, causes significant pain. It is clear that no major surgery is without some risk of serious disability or death. Although there is a good possibility that the surgery would improve claimant's condition, there is also a possibility that it would make her worse. A 75 percent chance of improvement has the necessary corollary of a 25 percent chance of no improvement or of worsening. Claimant may worsen without regard to the surgery. This is exactly the kind of situation in which there can be more than one possible reasonable answer. Claimant balanced the risks as she understood them against the potential benefits and concluded that she would not consent to the surgery. We cannot say that her

decision is outside the range of decisions reasonable people might make. She is entitled to an award of permanent total disability.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Marie H. Bradshaw, Claimant.

BRADSHAW,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Respondent.

(82-00795; CA A28229)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed February 17, 1984. Former opinion filed January 18, 1984, 66 Or App 751, 675 P2d 519 (1984).

Larry N. Sokol, Portland, for petition.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Petition for reconsideration allowed; reversed and remanded for determination of extent of disability.

GILLETTE, P. J.

Claimant appeals a Workers' Compensation Board order granting her 70 percent scheduled permanent partial disability for the loss of her left foot and denying her claim for permanent total disability. The issue on appeal is whether claimant has shown that her disabling headaches are causally related to her foot injury. We originally affirmed the case without opinion. *Bradshaw v. SAIF*, 66 Or App 751, 675 P2d 519 (1984). On reconsideration, we withdraw our original disposition, find that the headaches are compensable and remand to the Board for determination of the extent of permanent disability.

Claimant worked for many years as a newspaper carrier, delivering 200 to 400 papers a day by automobile. She was injured when she stepped on a board with a nail in it while she was walking up a driveway to deliver a paper. The wound became infected, causing her underlying diabetes to go out of control, and she was hospitalized for the treatment of both conditions. It took nearly a year for the infection to clear up; the foot continues to be of limited use. Before the injury claimant only rarely had headaches. She began having severe left frontal headaches while she was hospitalized, at a time when the infection was at its worst and before the diabetes was controlled. She has continued to have headaches since then. At times they are disabling; she regularly takes a prescription pain killer for them. Her treating physician referred her to specialists, but they were unable to find any organic cause. A

neurologist suggested that they might be muscle contraction headaches, but muscle relaxants produced no relief. In short, the chronology suggests that the headaches are the result of her injury and its complications, but no one has been able to indicate either what is causing the headaches or any mechanism that might relate them to the compensable injury.

We have always been hesitant to infer causation from chronological sequence. *Post hoc ergo propter hoc* is a classic logical fallacy. *See Edwards v. SAIF,* 30 Or App 21, 566 P2d 189, *rev den* 279 Or 301 (1977). Yet, as Sherlock Holmes noted, when one has excluded all other explanations, whatever remains, no matter how improbable, must be true. The headaches began when the effects of claimant's injury were at their

height, with a serious foot infection, high fever and uncontrolled diabetes. They were severe enough to delay her discharge from the hospital. Claimant and her physician made a thorough effort to discover their cause, including radiological examinations of her brain and its blood vessels and a full work-up by a neurologist, but every avenue they explored led to a dead end. Claimant's physician, who has over 30 years of family practice experience, ultimately concluded that the headaches and the injury are related.

> "* * * She did not have headaches before. They began immediately after the infection reached its peak and they have been a problem ever since.
>
> "* * * * *
>
> "* * * We have not been able to find an organic cause, no tumor or blood vessel or abscess which is what you suspect to begin with, that we have an abscess as a secondary event from the foot but we could not establish that.
>
> "* * * * *
>
> "It came on with a high fever and infection and just won't go away."[1]

The headaches must have some cause. The close connection between their onset and claimant's physical condition, combined with the inability to find any specific cause for them, lead us to agree with claimant's physician's application of Sherlock Holmes' principle. We find it more probable than not that the headaches were caused by the direct effects of claimant's injury and, therefore, that they are compensable.[2] The remaining question is extent of disability. On this record, it is best for the Board to determine that in the first instance.

Reconsideration allowed; reversed and remanded for determination of extent of disability.

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[1] Claimant's physician also dismissed hypertension and muscle contraction as possible causes of the headaches.

[2] This case is distinquished from *Edwards v. SAIF, supra,* because the chronological connection here between the injury and the allegedly compensable condition is much closer, because of the careful elimination of all alternative causes and because of claimant's physician's opinion that the conditions are related.

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Darrell W. Carr	36 Van Natta 16 (1984)	160,327,790,1103,1146,1196,1199,1230,124
Dwayne G. Cary	36 Van Natta 265 (1984)	768,791
Ruth M. Case	33 Van Natta 490 (1981)	73
Bonnie B. Cave	34 Van Natta 1149 (1982)	892
David Cheney	35 Van Natta 109 (1983)	1245
Harold R. Chester	35 Van Natta 874 (1983)	370
Joean Cisco	34 Van Natta 1030 (1982)	44,1179,1305
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Michael Cochran	35 Van Natta 1726 (1983)	1103
Dick A. Comstock	36 Van Natta 1115 (1984)	1145
Ora M. Conley	34 Van Natta 1698 (1982)	152,883
Betty L. Counts	35 Van Natta 1356 (1983)	21,720,1120
Betty L. Counts	36 Van Natta 18 (1984)	720,1120
Robert D. Craig	36 Van Natta 355 (1984)	1104,1165,1374
Kathie L. Cross	34 Van Natta 1066 (1982)	637
Dennis P. Cummings	36 Van Natta 260 (1984)	782
Max D. Cutler	34 Van Natta 1480 (1982)	265,768
Sally K. Cutts	36 Van Natta 641 (1984)	1254
William J. Dale	34 Van Natta 747 (1982)	829
Bill B. Dameron	36 Van Natta 592 (1984)	600,1298
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Allen Davis	33 Van Natta 564 (1981)	1158
Patricia G. Davis	35 Van Natta 635 (1983)	69,334
Lorri K. Day	35 Van Natta 500 (1983)	1096
Howard Dean	36 Van Natta 213 (1984)	602
Patricia M. Dees	35 Van Natta 120 (1983)	114,265,1208,1290
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Barbara Dill	32 Van Natta 248 (1981)	1148
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Terry Dorsey	31 Van Natta 144 (1981)	114
DeWayne D. Dunlap	36 Van Natta 139 (1984)	143,343
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Hettie M. Eagle	33 Van Natta 671 (1981)	239,861
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Olive B. Elwood	35 Van Natta 205 (1983)	90
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Kathryn P. English	34 Van Natta 1469 (1982)	675
Richard Erzen	36 Van Natta 218 (1984)	230,782,1171
Billy J. Eubanks	35 Van Natta 131 (1983)	26,44,160,265,675,791,1061,1078,1184,1192
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John E. Russell	36 Van Natta 678 (1984)	1055,1057,1196
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Lucine Schaffer	33 Van Natta 511 (1981)	146,184,1290
Anna M. Scheidemante	35 Van Natta 740 (1983)	1144
Leroy R. Schlecht	32 Van Natta 261 (1981)	293,576
Charles M. Schwab	36 Van Natta 333 (1984)	1111
Paul Scott	35 Van Natta 1215 (1983)	21,720,807,901
Mark L. Side	34 Van Natta 661 (1982)	818,829,887
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Donald VanDinter	35 Van Natta 1574 (1983)	44
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Waunita M. Walker	36 Van Natta 44 (1984)	25,26,40,1057,1135
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Samuel Weimorts	32 Van Natta 198 (1981)	861
Ray A. Whitman	36 Van Natta 160 (1984)	146,327,747,1103,1146,1196
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Donald Wischnofske	34 Van Natta 664 (1982)	129,641,911,1254
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Adams, Herman A., 84-0041M (5/84)
Adams, Norman, 84-0379M (8/84)
Aldous, Edward T., 84-0232M (6/84)
Alexander, Ethridge, 84-0348M (9/84)
Alexander, Robin, 83-0211M (2/84)
Allmon, Thomas, 83-0121M (6/84)
Alvarez, Jerry, 84-0090M (5/84)
Anglin, Lorraine, 81-0061M (5/84)
Armstrong, Donald R., 84-02118 (6/84)
Asbill, Leroy, 84-0244M (6/84)
Asbill, Leroy, 84-0244M (7/84)
Ash, Robert A., 84-0193M (5/84)
Azar, Lily A., 83-0031M (4/84)
Balcom, David L., 84-0202M (8/84)
Baldock, Jo Ann, 84-0069M (3/84)
Baldwin, Michael T., 84-0183M (5/84)
Bales, James C., 84-0052M (3/84)
Ball, Patrick, 84-0403M (9/84)
Barber, Vivian L., 83-0124M (7/84)
Barker, Donald D., 83-0364M etc. (8/84)
Barker, Donald, 83-0364M etc. (1/84)
Barnes, Ervin J., 84-0029M (5/84)
Bass, Donald A., 82-0056M (3 & 4/84)
Bass, Donald, 84-0293M (8/84)
Bayne, William D., 83-0169M (6/84)
Beaty, Howard V., 84-0182M (7,8/84)
Beaty, Robert J., 84-0198M (6/84)
Becker, Dennis W., 84-0426M (9/84)
Beers, Mark E., 84-0283M (8/84)
Benedict, Mitchell, 84-0200M (5/84)
Benintendi, Cecil, 84-0371M (8/84)
Bennett, Ronald E., 84-0109M (4/84)
Benton, James E., 84-0304M (7/84)
Berg, Dale V., 84-0234M (6/84)
Bergamo, Terry, 83-0390M (1/84)
Betterton, James R., 83-0339M (6/84)
Birdsell, Robert, 83-0241M (1/84)
Bjornsen, Bjorn, 84-0005M (2/84)
Black, Douglas, 83-0286M (8/84)
Blum, Barbara, 84-0211M (5/84)
Bonnin, Raymond, 84-0382M (9/84)
Bostrom, Bradford L., 84-0108M (5/84)
Boutwell, Emma J., 83-0318M (7/84)
Bowers, James, 83-0392M (1/84)
Bowlin, Alan M., 83-0278M (6/84)
Boyles, Gary, 84-0125M (4/84)
Bradbury, Robert, 84-0376M (9/84)
Bray, Bruce D., 84-0011M (1, 3/84)
Brett, Ralph E., 84-0028M (5/84)
Briley, Carroll L., 84-0356M (8/84)
Briley, Pat, 83-0212M (8/84)
Brill, Guy A., 84-0073M (5/84)
Brink, Lloyd Arthur, 83-0377M (3/84)
Brister, Lloyd, 84-0178M (5/84)
Britt, William T., 83-0202M (1/84)
Brong, Dessie L., 84-0334M (8/84)
Bronson, Teddi, 84-0320M (8/84)
Bronson, Teddi, 84-0320M (9/84)
Brooks, Clarence L., Sr., 84-0328M (8/84)
Brown, Charles, 84-0104M (6/84)
Brown, Frank G., 83-0129M (7/84)
Brown, Gary O., 84-0266M (8/84)
Brown, James W., 84-0072M (4/84)
Brown, Lois R., 83-0276M (2/84)
Brown, Tamara J., 84-0048M (5/84)
Bryan, Thomas, 84-0141M (6/84)
Bryant, Kenneth E., 82-0143M (2/84)
Buck, Nicholas J., 83-0296M (4/84)
Buckshnis, Rick L., 83-0135M (6/84)
Burke, Barbara, 84-0118M (3/84)
Burke, Walter, 84-0327M (8/84)
Bustamante, Enrique, 83-0167M (3/84)
Calawa, Glenn T., 84-0134M (4,6/84)
Caldwell, Jay G., 84-0138M (4,9/84)
Calkins, Carl L., 84-0169M (5/84)
Camp, Noland Dean, 84-0062M (3/84)
Campbell, Betty J., 83-0235M (2/84)
Campbell, Donna J., 84-0046M (2/84)
Campbell, Donna, 84-0046M (9/84)
Carmien, James, 84-0004M (2/84)
Carothers, Norman, 84-0424M (9/84)
Carpenter, Carl, 84-0165M (4/84)
Carter, Dorothy, 84-0133M (4 & 5/84)
Castle, Melvin O., 84-0267M (7/84)
Chaffee, Ronald D., 84-0450M (9/84)
Chapman, Robert E., 84-0177M (5/84)
Charpentier, Adrienne, 83-0383M (1/84)
Chew, Vernon, 83-0376M (2/84)
Chrestensen, Robert P., 84-0114M (6/84)
Christensen, Marian R., 84-0333M (8/84)
Church, Denise M., 84-0093M (3/84)
Church, Denise, 84-0093M (7/84)
Clark, William L., 84-0206M (7/84)
Clemons, Richard E., 82-0185M (4/84)
Clevenger, Delmer, 84-0346M (9/84)
Clevenger, Junior Ray, 84-0146M (4/84)
Coats, Thomas, 82-0041M (7/84)
Coleman, Barbara I., 84-0335M (7/84)
Collier, James, Jr., 84-0317M (9/84)
Combs, Harold, 83-0015M (6/84)
Compton, James, 84-0001M (1/84)
Cook, Joyce C., 83-0269M (5/84)
Cooper, Charles, 84-0338M (8/84)
Cooper, Wayne D., 83-0387M (2/84)
Corbett, Gary Lee, 84-0031M (3,5/84)
Cox, Reba Jean (Taylor), 84-0076M (7/84)
Crawley, Danny W., 84-0409M (9/84)

Name, WCB Number (Month/Year)
Cremin, John J., 84-06122 (7/84)
Daggett, Shirley, 84-0021M (5/84)
Dameron, Bill B., 82-0287M (4/84)
Daniel, Frederick, 84-0312M (8/84)
Darlington, Michael, 84-0270M (8/84)
Davenport, Jack A., 84-0226M (5/84)
Davis, Alan J., 84-0120M (4,8/84)
Davis, Jefferson, 82-0261M (4/84)
Davis, Wallace J., 83-0029M (1/84)
Decker, Mike A., 84-0387M (8/84)
Delsman, Bernard F., 84-0366M (8,9/84)
Dicintio, Robert N., 84-0175M (7/84)
Dickerson, Ruby Lee, 82-0098M (3/84)
Dillworth, William, 84-0263M (6,7/84)
Dinwiddie, Dale, 84-0302M (7/84)
Dix, Ingrid, 84-0009M (5/84)
Dockery, William A., 84-0085M (3/84)
Donaldson, Richard, 81-0167M (6,9/84)
Donathan, Wilson W., 83-0110M (3/84)
Dooley, Stephen C., 84-0245M (6/84)
Dority, Patrick J., 84-0039M (2/84)
Downing, Robert, 84-0316M (7/84)
Driggers, Roger A., 84-0248M (6/84)
Dunigan, Cecil R., 84-0056M (5/84)
Dupont, Ruben F., 84-0123M (3/84)
Durbin, David D., 83-0379M (3/84)
Durst, Leroy, 83-0360M etc. (3/84)
Duval, Roger A., 84-0042M (2/84)
Dvorak, Diane, 84-0299M (8/84)
Erickson, John P., 84-0368M (9/84)
Erickson, Marvin, 84-0189M (5/84)
Ethridge, Roy D., 83-0186M (6/84)
Evans, Ainslee D., 83-0188M (1/84)
Farley, Mary, 84-0423M (9/84)
Farrier, Joan C., 84-0033M (5/84)
Feammelli, Tony, 84-0038M (5/84)
Feasel, Virgil W., 84-0049M (5/84)
Fellows, Vernon L., 84-0014M (1/84)
Ferguson, Donald E., 82-0248M (3/84)
Ficker, Joseph, 83-0367M (7/84)
Fite, Kristi K., 84-0275M (6/84)
Flannery, Michael T., 83-0242M (2/84)
Foltz, Doyle C., 84-0148M (5/84)
Fowler, Charles O., 84-0053M (3,6/84)
France, Roger C., 84-0084M (5,6/84)
Franke, Donald M., 82-0039M (1/84)
Franke, Donald, 84-0158M (5,8/84)
Frear, James, 82-0291M (1,2,6,7/84)
Freeman, Nadine, 84-0247M (9/84)
Friend, Lonita D., 84-0295M (9/84)
Frydendall, Cecil L., 84-0216M (7/84)
Fuhrmann, Kyong, 84-0411M (9/84)
Funk, Robert S., Jr., 83-0371M (2/84)
Gairson, Mark, 84-0019M (5/84)
Gardner, Ben D., 83-0391M (1/84)
Gardner, Walton A., 83-0049M (6/84)
Gay, Walter A., 84-0136M (5/84)

Name, WCB Number (Month/Year)
Gentry, Alice M., 84-0210M (6/84)
Gergen, Georgia, 83-0145M (1/84)
Getner, Donald, 84-0065M (4/84)
Giffin, Jerry Dean, 83-0079M (1/84)
Goodlow, Cleatis P., 84-0063M (2/84)
Goodridge, David L., 84-0195M (5/84)
Gough, Peter, 84-0122M (4/84)
Grebenc, Andrew J., 84-0347M (9/84)
Greer, Annie Jo, 84-0113M (4/84)
Gregor, Robert, 84-0429M (9/84)
Greve, Everett W., 84-0255M (7/84)
Griffin, Ronald D., 84-0236M (6/84)
Grijalva, Pat, 84-0374M (8/84)
Hackett, Leslie J., 84-0309M (7/84)
Hammer, Charles, 83-0254M (1/84)
Hampton, Frank T., 83-0100M (8/84)
Haney, Terry P., 84-0102M (5/84)
Hannon, James, 83-0218M (8/84)
Hansen, William, 84-0188M (5/84)
Haron, Louis, 83-0348M etc. (1/84)
Harris, Jack G., 84-0337M (9/84)
Harris, Sheri D., 84-0225M (5/84)
Harrison, Thomas, 84-0412M (9/84)
Hartman, James, 84-0253M (7/84)
Hartman, James, 84-0253M (7/84)
Hash, Stephen L., 84-0094M (3/84)
Hawkins, Floyd E., 83-0382M (2/84)
Hawthorne, Charlotte, 84-0191M (5/84)
Hay, Kenneth A., 84-0239M (8/84)
Heap, Albert, 84-0079M (6/84)
Heart, Betty C., 82-0303M (8/84)
Hendrickson, Bob G., 84-0051M (4 & 5/84)
Hendriz, Melvin E., 84-0277M (6/84)
Heth, John W., 82-0290M (1, 2/84)
Hetrick, Gregory A., 83-0032M (6,8/84)
Hight, Liddie B., 84-0265M (7/84)
Hinzman, Bernie, 83-0097M (1/84)
Hoff, Harley R., 84-0032M (2,6/84)
Hoffman, Robert, 84-0205M (7/84)
Holland, Judith, 84-0034M (2/84)
Hollenbeck, William, 84-0218M (8/84)
Holley, Billy J., 84-0117M (5/84)
Holliday, Richard, 83-0024M (6/84)
Holling, Robert, 84-0110M (4/84)
Holly, Willard H., 84-0352M (8/84)
Holt, Melvin, 84-0020M (4/84)
Hoskins, Charles E., 84-0100M (3/84)
Howard, Gerald B., 84-0172M (6/84)
Howard, John, 84-0166M (6/84)
Howard, Wesley, 84-0394M (9/84)
Howell, Michael, 83-0107M (7/84)
Hudson, Ronald J., 84-0017M (1/84)
Hughes, Harvey, 84-0340M (8/84)
Hunter, Jeffery K., 84-0066M (3/84)
Huntsucker, Clifford, 84-0081M (4/84)
Hutchins, Francis, 83-0331M (3/84)
Hutchins, Francis, 83-0331m (8/84)

Name, WCB Number (Month/Year)

Hutchison, Joseph, 83-0393M (1/84)
Idlewine, James, 81-0197M (5/84)
Imdahl, Herbert M., 84-0026M (1/84)
Imdahl, Herbert, 84-0405M (8/84)
Ivie, Edward H., 84-0249M (6/84)
Jackson, Eugene, 83-0153M (5/84)
Jackson, Margarite, 84-0256M (9/84)
Jackson, Robert D., 83-0025M (5/84)
Jackson, Robert D., 83-0025M (8/84)
James, Ronald J., 84-0341M (8/84)
Jerome, David, 82-0137M (7/84)
Joanis, Marvin A., 84-0344M (8/84)
Johnson, Dorothy L., 84-0215M (6/84)
Johnson, Douglas, 84-0003M (1/84)
Johnson, Kenneth, 84-0154M (4/84)
Johnson, Lester, 82-0036M (8/84)
Johnson, Vernon, 84-0087M (3/84)
Johnston, Flora, 84-0354M (8/84)
Jones, Danny J., 84-0016M (2/84)
Jones, Dennis J., 84-0280M (7/84)
Jorgensen, Harold, 84-0194M (7/84)
Josi, Robert E., 84-0163M (4/84)
Joyner, Judy, 84-0375M (9/84)
Kelley, Robert D., 83-0229M (9/84)
Kemmerer, Kenneth, 84-0127M (5/84)
Kephart, Archie, 81-0173M (3/84)
Kerekes, Karen L., 84-0057M (2/84)
Keyser, John P., Jr., 82-0191M (9/84)
Keyser, John, Jr., 82-0191M (7/84)
King, Edna, 84-0036M (4/84)
King, Mark, 84-0250M (6/84)
Kirchhoff, Rex, 84-0140M (6/84)
Knupp, Patricia, 83-0304M (4/84)
Kosack, Dolores A., 82-0246M (8/84)
Kuhn, Ronald C., 84-0077M (5/84)
Kurtz, Judy E., 84-0012M (5/84)
Kurtz, Judy, 84-0012M (8/84)
Kutch, Gerald, 82-0322m (2/84)
Kyle, Steve, 84-0008M (1/84)
Laing, George J., 83-0219M (6/84)
Lakey, John, 84-0010M (2/84)
Lamb, Verl E., 84-0153M (4,6/84)
Laney, Walter, 84-0185M (5/84)
Langley, Billey, 84-0192M (5/84)
Larsen, Jorgen, 83-0288M (9/84)
Larson, Melvin, 84-0364M (8/84)
Lee, Dwight L., 84-0096M (3/84)
Lee, Richard Allen, 84-0171M (6/84)
Leedy, Melvin, 84-0023M (4/84)
Lewis, Wilbur A., 82-0160M (7/84)
Lincoln, Curtis, 84-0181M (4/84)
Lincoln, Curtis, 84-0367M (9/84)
Lindsley, Stanley A., 81-0064M (7/84)
Lister, Yvonne, 83-0378M (6/84)
Lloyd, Audley, Jr., 83-0182M (8/84)
Locks, Albert, 84-0149M (6/84)
Loftis, Charles J., 84-0142M (4/84)

Name, WCB Number (Month/Year)

Logan, Eugene A., 84-0197M (6/84)
Logan, Richard, 83-0302M (5/84)
Long, Larry, 83-0115M (4/84)
Lopez, Alex, 81-0315M (2/84)
Lorett, John L., 82-0327M (4/84)
Louden, Mariva, 83-0130M (5,7/84)
Lovelady, John L., 84-0135M (4/84)
Lund, DuWayne, 84-0390M (8/84)
Lundsten, Betty, 83-0319M (1/84)
Lux, Virgil, 84-0380M (8/84)
Lynch, Jesse, 84-0047M (4/84)
Lyon, Claude, 84-0159M (8/84)
Mack, John, 83-0034M (4/84)
Maddox, Gary, 83-0321M (1, 1/84)
Manwill, Moyle C., 83-0140M (1/84)
Marks, Norman L., 84-0310M (7/84)
Martin, David, 84-0207M (8/84)
Martin, James, 82-0054M (1,2,3/84)
Martin, Lawrence V., 84-0151M (6/84)
May, Ronald, 84-0258M (7/84)
McClendon, William G., 83-0375M (5/84)
McGinnis, Kenneth L., 84-0147M (5,8/84)
McKean, Raymond, 83-0259M (4/84)
McMullen, Flora, 84-0214M (5/84)
McTimmonds, Rodney, 83-0384M (3/84)
Menke, Carlos R., 84-0282M (9/84)
Mercer, Joan, 83-0342M (3 & 5/84)
Michael, Vernon, 81-0201M (4 & 5/84)
Mickelson, Roger M., 84-0208M (6/84)
Milano, Catherine, 84-0186M (8/84)
Milich, Forrest, 84-0386M (9/84)
Millard, Clinton L., 84-0145M (7/84)
Miller, Beverly, 84-0281M (8/84)
Miller, Richard K., 84-0311M (7/84)
Mitchell, Robin, 84-0243M (6/84)
Mitchell, Sharron, 84-0397M (9/84)
Mobley, Michael, 84-0319M (7/84)
Moisio, Leo, 84-0228M (8/84)
Monteith, Norris, 84-0287M (8/84)
Moody, Ole, 84-0064M (4/84)
Moody, Otis, 84-0357M (9/84)
Mooers, Leslie, 84-0040M (6/84)
Moore, Robert L., 84-0112M (3/84)
Moore, Stephen H., 84-0130M (4/84)
Moraga, Ernest, 83-0373M (4/84)
Moreno, Erica E., 83-0152M (7/84)
Morris, Lonnie D., 84-0221M (5/84)
Mortensen, Lewis, 84-0022M (1,7/84)
Morton, William E., 83-0111M (8/84)
Morton, William, 83-0111M (1/84)
Mosier, Marion R., 84-0095M (3/84)
Moyer, Phillip Sr., 84-0083M (3/84)
Muehlhauser, Eugene, 84-331M (8/84)
Murphy, Patrick, 84-0184M (7/84)
Murray, Dorothy, 83-0330M (6/84)
Murray, Robert O., 84-0220M (6/84)
Mustoe, Erwin R., 83-0388M (1/84)

OWN MOTION JURISDICTION

Name, WCB Number (Month/Year)

Myler, John A., Sr., 84-0013M (7/84)
Myler, John, Sr., 84-0013M (4/84)
Neault, Marjie M., 83-0329M (3/84)
Nelson, Margie, 84-0027M (2/84)
Netland, Janis F., 83-0352M (8/84)
Newberry, James D., 81-0110M (4/84)
Nichols, Samuel L., 83-0385M (1/84)
Nicholson, Karen, 82-0285M (8,9/84)
Nicklin, David, 84-0391M (9/84)
Nicks, Edward, 83-0158M (1/84)
Nixon, Elmer O., 81-0230M (4/84)
Norton, Alberta M., 81-0129M (3/84)
Nugent, Carole, 84-0105M (4/84)
Olson, Allan D., 84-0161M (9/84)
Pace, George W., 84-0290M (7/84)
Pacheco, Willadeane, 84-0006M (1/84)
Palmer, Russell E., 84-0106M (4/84)
Palmquist, Joann, 84-0227M (8/84)
Park, Susan L., 84-0246M (6/84)
Park, Thomas D., 84-0092M (3/84)
Parker, Donald, 84-0002M (1,6/84)
Parker, Lee Roy, 84-0074M (3, 4 & 5/84)
Parkerson, Jack, 84-0190M (7/84)
Parks, John, 82-0282M (5/84)
Parsley, Donald, 84-0332M (7/84)
Patterson, Archie B., 84-0285M (9/84)
Patterson, Jere A., 84-0363M (9/84)
Patterson, Katherine, 84-0209M (5/84)
Paul, Vickie E., 84-0362M (8/84)
Paulsen, John A., 83-0048M (1/84)
Payment, Robert H., 84-0167M (5/84)
Peabody, Eileen, 83-0053M (7/84)
Pender, John, 84-268M (8/84)
Penry, Opal, 84-0401M (9/84)
Peterson, Edward, 84-0252M (6/84)
Petrie, Terry, 84-0204M (5,6,8,9/84)
Peyton, Gary, 82-0253M (2/84)
Phipps, Judith, 84-0305M (8/84)
Phoenix, Scott R., 84-0251M (6/84)
Poelwijk, James, 83-0340M (1/84)
Pointer, Myrna, 84-0176M (7/84)
Poplin, James, 84-0257M (6/84)
Posey, James H., 84-0274M (6/84)
Prall, Anna M., 84-0418M (9/84)
Prewitt, Paul, 84-0321M (7/84)
Purdy, Charles A., 83-0374M (1/84)
Purdy, Charles A., 83-0374M (7/84)
Pyle, June, 82-0286M (5/84)
Raines, Donald, 84-0261M (6/84)
Ralston, Dean J., 84-0119M (5/84)
Rampenthal, Marquita, 84-0058M (2/84)
Randall, Nathan C., 83-0127M (5/84)
Rathman, Robert D., 82-0219M (2/84)
Rauschert, John, 83-0353M (1,5,6/84)
Reeves, Violet I., 84-0259M (6/84)
Rekow, Michael R., 84-0173M (5/84)
Rengo, Bruce E., 84-0355M (9/84)

Name, WCB Number (Month/Year)

Rhine, Rachel, 84-0111M (4/84)
Rice, Mary Jane, 83-0314M (2/84)
Richards, Herbert E., 82-0084M (5/84)
Riddle, Charles, 84-0330M (7/84)
Rider, Kathleen, 84-0201M (8/84)
Riggins, Paul, 84-0054M (5/84)
Roberts, Starrlee E., 84-0416M (9/84)
Robinette, Gary, 83-0093M (5/84)
Rodgers, Roland, 84-0238M (6/84)
Roelle, Walter D., 84-0015M (1/84)
Roessel, Robert, 84-0359M (9/84)
Rose, Mike, 84-0336M (7/84)
Rose, Tim A., 84-0415M (8/84)
Ross, Max J., 84-0067M (3/84)
Roth, Vernon L., 83-0386M (2/84)
Roush, Richard L., 84-0018M (2/84)
Rowley, Steven J., 84-0294M (7/84)
Russell, Jed L., 84-0124M (7/84)
Ryan, Lawrence, 84-0160M (7/84)
Salanti, Michael, 84-0298M (7/84)
Salisbury, Jan L., 84-0025M (1/84)
Sanders, Loretta, 84-0306M (9/84)
Sandstrum, Jack, 84-0343M (8/84)
Sather, Einar, 84-0345M (8/84)
Schafer, Glenn E., 83-0161M (5/84)
Schneider, Arthur, 84-0378M (9/84)
Schulz, Donna, 84-0187M (5/84)
Schuster, Carrie, 82-0299M (4/84)
Schwingel, June Eleanor, 84-0156M (6,8/84)
Seth, Gary D., 84-0103M (5/84)
Severy, William D., 84-0383M (8/84)
Sevey, Gene, 84-0007M (2/84)
Sharman, Donald, 84-0377M (9/84)
Siemssen, Richard, 84-0219M (5/84)
Sikes, Billie, 81-0086M (1/84)
Sizemore, Addie Mae, 83-0368M (1/84)
Skipworth, Kenneth, 83-0283M (5/84)
Skiver, Paul W., 83-0343M (4/84)
Slinger, Edward, 84-0126M (3/84)
Smeltzer, Derral, 84-0229m (6/84)
Smith, Charles D., 82-0236M (5/84)
Smith, David, 84-0150M (4/84)
Smith, David, 84-0273M (8/84)
Smith, Joseph, 84-0400M (9/84)
Smith, Robert E., 84-0404M (8/84)
Smith, William F., 84-0353M (8/84)
Sorensen, Robert L., 84-0264M (6,7/84)
Sowell, Raymond L., 84-0370M (9/84)
Spickelmier, Forrest L., 84-0326M (8/84)
Sprague, Elnora M., 84-0349M (8/84)
Sprague, Elnora, 83-0205M (4/84)
St. Clair, Sharon, 84-0152M (4/84)
St. Onge, Jim, 82-0165M (5/84)
Stallsworth, James, 84-0170M (5/84)
Stevenson, Kenneth L., 84-0303M (7/84)
Stianson, Milton R., 83-0247M (7,8/84)
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