VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 43

(Pages 815-1614)

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

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

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CITE AS

43 Van Natta ____ (1990)

In the Matter of the Compensation of
LANNY L. MILLS, Claimant
WCB Case No. 90-11034
ORDER ON REVIEW
Des Connall, Claimant Attorney
Gordon L. Welborn, Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of Referee Leahy's order which increased claimant's scheduled permanent disability award for loss of use or function of the right arm from 5 percent (9.6 degrees), as awarded by Determination Order, to 30 percent (57.6 degrees). On review, the issue is extent of scheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and supplement with the following findings. Prior to surgery, Dr. Kramer, claimant's former treating osteopathic physician, restricted claimant to lifting 35 pounds with his right arm and prescribed a tennis elbow splint.

Claimant's current treating physician, orthopedic surgeon Baum, performed a right lateral epicondylar release. This surgery did not improve claimant's condition. Dr. Baum notes that claimant continues to require wrist and elbow bracing, and has advised claimant to avoid heavy lifting.

Claimant continues to experience discomfort performing his regular job duties. He cannot lift at work without wearing wrist/arm braces.

FINDING OF ULTIMATE FACT

Claimant has sustained a 10 percent loss of use or function of his right arm as a result of his compensable elbow injury.

CONCLUSIONS OF LAW AND OPINION

Finding clear and convincing evidence of impairment greater than that contemplated under the standards, the Referee increased claimant's scheduled permanent disability award from 5 percent to 30 percent. The insurer argues that claimant failed to meet the clear and convincing standard of evidence and, therefore, contends that claimant's disability should be rated under the "standards." Nevertheless, the insurer indicates that claimant is entitled to a 5 percent disability award based on a surgical procedure not specified in the standards.

For purposes of determining injury-related permanent partial disability, former ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010(1).

Because claimant became medically stationary on March 1, 1990 and his claim was closed by Determination Order on April 13, 1990, the "standards" in effect January 1, 1989 are used in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability. Former OAR 436-35-010(1).

Disability Under the Standards

In his March 1, 1990 closing examination, Dr. Baum reported that claimant has mild permanent impairment consisting primarily of right arm pain with repetitive use. The doctor noted that claimant has no loss of range of motion, no muscle weakness, no sensory loss, and no atrophy. Although claimant has undergone a right lateral epicondylar release, that surgical procedure is not covered by the standards. Former OAR 436-35-110(4)(a) through OAR 436-35-110(4)(k). Thus, there is no basis to award claimant a 5 percent impairment value for his elbow surgery as the insurer suggests. Accordingly, other than a chronic condition limiting repetitive use, claimant has no rateable elbow/arm impairment for which a value may be assigned under the "standards." See former OAR 436-35-100(1) through OAR 436-35-100(8) and former OAR 436-35-110(3).

Claimant is entitled to an award of 5 percent for loss of repetitive use of the right arm. Former OAR 436-35-010(7). Claimant's total impairment under the standards is, therefore, 5 percent.

Disability Outside the Standards

Either party may establish that the record as a whole constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable," free from confusion, fully intelligible and distinct. Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

On review, claimant urges the Board to affirm the Referee's award of 30 percent scheduled permanent disability. We agree that claimant is entitled to a greater impairment value than that awarded under the standards. Dr. Kramer initially restricted claimant to lifting 35 pounds with his right arm and prescribed a tennis elbow splint. Although claimant later underwent a right lateral epicondylar release, this procedure did not improve claimant's condition. Thereafter, Dr. Baum also advised claimant to avoid heavy lifting.

The record as a whole clearly establishes that claimant continues to require wrist and elbow bracing in order to perform his at-injury job. Claimant's right elbow condition is disabling and results in loss of use or function beyond the 5 percent indicated by the standards. We, therefore, conclude that claimant has shown by clear and convincing evidence that he suffers scheduled permanent disability of 10 percent due to his right epicondylitis with unsuccessful lateral epicondylar release.

ORDER

The Referee's order dated September 24, 1990 is modified. In lieu of the Referee's award and in addition to the 5 percent (9.6 degrees) scheduled permanent disability awarded by the Determination Order, claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability, giving him a total award to date of 10 percent (19.2 degrees) scheduled permanent disability for loss of use or function of the right arm. Claimant's attorney fee shall be adjusted accordingly.

In the Matter of the Compensation of
DAVID A. STEINER, Claimant
WCB Case No. TP-91002
THIRD PARTY DISTRIBUTION ORDER
Pozzi, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board to resolve a dispute concerning the amount of SAIF's lien for its expenditures for compensation under ORS 656.593(1)(c) it may recover from a third party judgment. ORS 656.593(1)(d). Specifically, the dispute pertains to whether SAIF's lien includes an attorney fee paid out of the increased permanent disability compensation awarded by a Referee order. We conclude that attorney fees payable out of claimant's permanent disability award are compensation and, as such, SAIF is entitled to reimbursement for such claim costs as part of its third party lien.

FINDINGS OF FACT

In July 1984, while working as an installer, claimant sustained a compensable injury to his feet when he fell 20 feet and landed on his heels. He suffered closed fractures to both feet, which were subsequently casted. In September 1984 claimant returned to work performing light duty work as an estimator. Because of persistent pain complaints, his ability to walk, stand, squat, stoop, or drive a vehicle has been significantly altered.

In February 1985, his claim was closed by Determination Order. Claimant was awarded 30 percent scheduled permanent disability for loss of use or function of the left foot and 25 percent for loss of use or function of the right foot. Claimant requested a hearing, which resulted in a November 1985 Referee's order. Claimant's awards were increased to 75 percent scheduled permanent disability for the left foot and 65 percent for the right foot. Claimant's attorney was awarded an attorney fee payable out of the increased compensation granted by the Referee's order. The attorney fee equaled 25 percent of the increased compensation, not to exceed $2,000.

Claimant retained legal counsel to pursue a third party action for damages arising from his compensable injury. A civil action was instituted, which eventually resulted in a judgment against the third party for negligence totalling $383,585.75.

SAIF notified claimant of its third party lien, asserting that it had incurred claim costs totalling $30,706.46. SAIF's lien included those portions of the permanent disability awards payable to claimant as well as the $2,000 attorney fee.

Shortly after the third party judgment became final, claimant's counsel forwarded to SAIF $28,706.46. This sum represented SAIF's current lien, less the $2,000 attorney fee. SAIF accepted the payment as a partial payment, but continued to seek reimbursement of the disputed attorney fee. Noting that its third party lien for claim costs was actually $30,465.92, SAIF requested $1,759.46 as full reimbursement.

CONCLUSIONS OF LAW

The statutory formula for the allocation of damages from a third party judgment under ORS 656.593(1) is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Attorney fees and costs incurred in pursuit of the third party recovery

shall be initially disbursed. Then the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b).

The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. ORS 656.593(1)(c). Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278. Id. Any remaining balance shall be paid to the worker. ORS 656.593(1)(d). Finally, any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the Board. Id.

Here, the dispute centers on whether the attorney fee awarded by the Referee's order to be paid out of claimant's increased permanent disability award is compensation for purposes of ORS 656.593(1)(c). We conclude that such an attorney fee is compensation and, thus, is reimbursable as a claim cost from a third party recovery. Our conclusion is based on the following reasoning.

"Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8). Attorney fees a claimant recovers against an insurer after prevailing against a denial of a claim are not recoverable by the insurer as an "other cost" of the claim under ORS 656.593(1)(c). Schlecht v. SAIF, 60 Or App 449, 457 (1982). However, attorney fees which are payable out of claimant's compensation retain their identity as compensation. SAIF v. Gatti, 72 Or App 106 (1985); Candy J. Hess, 37 Van Natta 12, 13 (1985); Robert G. Perkins, 36 Van Natta 1050, 1051 (1984).

Claimant argues that the third party statutes never intended to permit a paying agency to recover as part of its lien an attorney fee payable out of a sucessfully appealed Determination Order. Instead, claimant submits that the paying agency's lien should be limited to those claim costs paid to the worker.

We disagree with claimant's contention. ORS 656.593(1)(c) expressly excludes a paying agency from recovering expenditures for compensation payable under ORS 656.273 and 656.278. Considering such an expressed intention, had the legislature further intended to prohibit a paying agency from recovering as claim costs attorney fees which it had been required to pay out of claimant's compensation, we believe that the statute would have so provided. Furthermore, since the issue presented for our resolution concerns whether the attorney fee allowed from claimant's permanent disability award is compensation rather than an insurer-paid attorney fee as an "other cost" of the claim, the Schlecht holding has no application. Lacking neither a legislative directive nor an applicable court holding, we continue to adhere to our prior decisions which support the proposition that attorney fees payable out of compensation retain their identity as compensation under Chapter 656. Because such fees are compensation, they are reimbursable from claimant's third party recovery under ORS 656.593(1)(c).

In reaching this conclusion, we wish to emphasize that all of the permanent disability compensation granted by the Referee's order was awarded to claimant. Yet, in accordance with the Board's attorney fee rules (then OAR 438 Division 47; now OAR 438 Division 15), and ORS 656.386(2), a portion of this compensation was paid directly to his attorney. Thus, we are not persuaded by claimant's attempt to characterize the attorney fee as never part of his compensation.

Accordingly, claimant's counsel is directed to forward $1,759.46 to SAIF which shall constitute its entire share of the third party recovery. ORS 656.593(1)(c), (d).

IT IS SO ORDERED.

April 2, 1991 Cite as 43 Van Natta 819 (1991)

In the Matter of the Compensation of
JOHN W. KUYKENDALL, Claimant
WCB Case No. TP-90056
THIRD PARTY ORDER ON RECONSIDERATION
Smith & Smith, Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

On March 21, 1991, we abated our March 8, 1991 Third Party Distribution Order, which had held that the SAIF Corporation was entitled to $33,167.50 of the $37,248.53 balance remaining from a third party recovery. We took this action to consider claimant's motion that we modify our order to find that the third party recovery was by means of judgment rather than by settlement and to direct SAIF rather than claimant's counsel to provide claimant with the $4,081.03 balance remaining from the recovery after distribution of its share of the proceeds. Having received SAIF's response, we proceed with our reconsideration.

Upon further review, we find that the third party recovery was realized through a judgment and not by settlement as stated in our prior order. Therefore, our order is amended to reflect this modification. In addition, since SAIF has been in possession of the $37,248.53 remaining balance of proceeds from the third party judgment and because we have found that it is entitled to recover $33,167.50 as its share of the recovery, SAIF rather than claimant's counsel is directed to pay the remaining $4,081.03 to claimant under ORS 656.593(1)(d). Based on SAIF's response, this action has already apparently been taken.

Accordingly, as supplemented and modified herein, we adhere to and republish our March 8, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

April 3, 1991 Cite as 43 Van Natta 819 (1991)

In the Matter of the Compensation of
EVELYN CHRISTENSON, Claimant
WCB Case No. C1-00240
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Whitehead & Klosterman, Claimant Attorneys
Nelson, et al., Defense Attorneys

On March 12, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $25,000 by Liberty Northwest Insurance Corporation, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. In a release signed in conjunction with the claim disposition agreement, claimant agrees to release her right to reemployment and claims for unemployment compensation benefits with the employer. We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable," subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim. OAR 436-60-005(9). See also OAR 438-09-001(1). The underscored portion of the rule makes clear that only rights and/or obligations under ORS Chapter 656 may be released by a claim disposition agreement.

Here, the proposed disposition releases rights and obligations under ORS Chapter 656, but also purports to release claimant's right to reemployment under ORS Chapter 659, and to unemployment claims under ORS Chapter 657. See ORS 659.415; ORS 657.155. The release of the right to reemployment and unemployment benefits, because they concern matters outside of ORS Chapter 656, are not proper matters for disposition under ORS 656.236 and the rules promulgated thereunder. Karen Vearrier, 42 Van Natta 2071 (1990). Indeed, there is no authority which permits us to approve a release of reemployment rights. For those reasons, the proposed disposition is not a "claim disposition agreement" as defined by OAR 438-09-001(1). Accordingly, we are without authority to approve any portion of the proposed disposition.

We are aware that the parties have attempted to establish a separation between the release of rights under ORS 656 and ORS 659. However, the release specifically states that the consideration for release of rights under ORS 656 also constitues consideration for release of rights under ORS 659. It is clear that we are dealing with a single bargain. Therefore, the documents are inseparable.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD E. GONSHOROWSKI, Claimant
WCB Case No. 90-12633
ORDER OF DISMISSAL
Connall & Lorenz, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation has moved the Board for an order dismissing claimant's request for review on the ground that the request was not timely filed. The motion is granted.

FINDINGS OF FACT

The Referee's order issued November 13, 1990. The order included notice of when (within 30 days) and where (with the Workers' Compensation Board) a request for review of the order should be filed. On December 18, 1990, the

Board received a letter from SAIF. SAIF's letter enclosed a letter from claimant expressing dissatisfaction with the Referee's November 13, 1990 order. Claimant's letter was dated December 11, 1990, postmarked on December 12, 1990, and addressed to SAIF's trial counsel. SAIF's date stamp indicates receipt of claimant's letter on December 13, 1990.

The Board's computer-generated letter acknowledging the request was mailed on December 20, 1990.

ULTIMATE FINDINGS

Claimant's request for review was not received by the Board within 30 days of the Referee's order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.298(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's November 13, 1990 order was December 13, 1990. Assuming that claimant's letter to SAIF's counsel constituted a request for Board review of the Referee's order, the request was received by SAIF on December 13, 1990, 30 days from the Referee's order. However, the record fails to establish that the request was mailed to, or received by, the Board within the statutory 30-day period. Consequently, we lack authority to review the order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

We are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the Referee's order. Moreover, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

In the Matter of the Compensation of
CAROL D. GOSS, Claimant
WCB Case No. 89-10994
ORDER ON REVIEW
Garlock & Smith, Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Myers, Cushing and Crider.

The self-insured employer requests review of Referee Shebley's order that: (1) declined to apply the doctrine of res judicata as a bar to claimant's claim for a low back and left hip condition; and (2) on the merits, set aside its

partial denial of the claim. On review, the issues are res judicata and compensability. We reverse.

FINDINGS OF FACT

On October 6, 1987, claimant compensably injured her right foot causing right foot, ankle and knee pain. In August 1988 claimant returned to work. Her foot later swelled and hurt.

A September 9, 1988 Determination Order awarded claimant 4 percent permanent disability for her right leg (knee) injury.

In November 1988, claimant's treating chiropractor, Dr. Phillips, took claimant off work because of left hip and low back pain. According to Phillips the left hip and low back pain was caused by placing extra weight on the left leg because of the accepted right ankle injury.

On December 9, 1988, the employer denied an aggravation claim, on the basis that "your condition has not worsened since your claim was previously closed." (Ex. 26-1). The denial was not challenged and became final by operation of law.

Claimant continued to treat with Dr. Phillips for identical low back and left hip conditions.

On May 16, 1989 the employer issued a partial denial, of claimant's current low back and left hip conditions on the basis that they were unrelated to the compensable right foot injury. (Ex. 44-1). Claimant appealed this denial.

ULTIMATE FINDINGS OF FACT

There was no change in claimant's condition or treatment during the interval between the December 1988 aggravation denial and the May 1989 partial denial.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the issues raised by the December 1988 aggravation denial were different from those raised by the May 1989 partial denial. We disagree.

"Preclusion by former adjudication," generally referred to as res judicata, is a "doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim." Drews v. EBI Companies, 310 Or 134 (1990). Preclusion by former adjudication includes "issue preclusion" and "claim preclusion".

Issue preclusion acts as a bar only when: (1) the same parties (2) actually litigate an issue of law or fact (3) which is necessary to (4) a valid and final judgment. Jimmy M. Campoz, 42 Van Natta 903 (1990). Because the December denial was not actually litigated to judgment, issue preclusion does not apply.

"Claim preclusion" precludes a plaintiff who has prosecuted one action against a defendant through to a final judgment from prosecuting another action against the same defendant where the claim in the second action is one based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Drews, supra at 140, citing Rennie v. Freeway Transport, 294 Or 319, 323 (1982). Claim preclusion does not require actual litigation. Where, as here, the December 1988 denial became final because claimant chose not to request a hearing,

she may not litigate the same claim or claims which arise from the same transaction or series of transactions. We conclude that the effect of the December 1988 denial was to finally determine that claimant's left hip and low back conditions were not compensable. Thus, the question is whether claimant's condition has changed so as to create a new set of operative facts that previously could not have been litigated.

Thus, claimant must show that her current low back and left hip condition is changed from her condition at the time of the December 1988 aggravation denial, which became final by operation of law. See Proctor v. SAIF, 68 Or App 333 (1984); Irene Jenson, 42 Van Natta 2838 (1990). Claimant's present claim for her low back and left hip condition is merely a different characterization of the identical conditions which led to the 1988 aggravation denial.[1] Claimant's treating chiropractor, Dr. Phillips, provided the same treatment for claimant's low back and left hip from November 1988 through July 1989. Moreover, Dr. Phillips' diagnosis regarding the left hip and low back conditions remained the same throughout this period.

Finally, there were no conditions present at the time of the May 1989 denial, that did not already exist when the December 1988 aggravation denial was issued. The fact that claimant now asserts her claim by another legal theory does not alter the preclusive effect of the denial, which became final through operation of law. Million v. SAIF, 45 Or App 1097, 1102 rev den 289 Or 337 (1980) (Res Judicata applies not only to every claim included in the pleadings, but every claim which could have been alleged under the same aggregate of operative facts).

Accordingly, we find that under the doctrine of claim preclusion, claimant is barred from litigating the compensability of her present low back and left hip condition. Because we have determined that claimant is precluded from litigating the merits of her current condition, we need not address compensability.

ORDER

The Referee's order dated March 5, 1990 is reversed. The insurer's denial is reinstated and upheld. The Referee's assessed attorney fee award of $2,257.50 is reversed.

[1] The dissent recognizes that the Restatement of Judgments 2d instructs us to determine pragmatically what constitutes a single transaction for purposes of claim preclusion. It then ignores that instruction. The dissent's characterization of the majority opinion is that we are saying that every time an aggravation denial is let stand, then there is a preclusive effect both on the question of a worsening and on the question of current medical services.

On the contrary, we are saying that under the facts of this particular case, the denial was not only a denial of a worsening, but was a denial of claimant's current condition because what had been claimed was that the aggravation was based on new conditions. In other words, we have viewed this case pragmatically and determined that the operative facts for purposes of claim preclusion are what was claimed and are not restricted to the narrow wording of the denial.

Board Member Crider, dissenting.

The panel's application of the doctrine of claim preclusion in this case is wrong. It is unfair to this claimant. Moreover, it will have the effect, not of minimizing litigation, but instead of forcing parties to undertake litigation of denials to which they do not object in order to preserve rights in a

compensable claim which have not been actually denied. If accepted principles of res judicata required this result, we would be compelled to accept this unfortunate result. Because I do not believe that the law compels this result, I dissent.

I.

In this case, claimant allowed a denial of aggravation to stand without challenge. She requested a hearing on a later denial of compensability of particular conditions. The panel holds that she is not entitled to a hearing on the second denial unless she can establish that her condition at the time of the second denial was different than her condition at the time of the first. Because the panel concludes that her condition was not different, the panel does not permit claimant to litigate the compensability of the denied conditions.

The res judicata effect of the first denial is much more limited than that given it by the panel. Before addressing the legal issues, let us review the facts.

II.

Claimant suffered a compensable injury affecting her right foot, ankle and knee. She received medical services. Following claim closure, claimant changed physicians. Her new physician, Dr. Phillips, reported pain in the right foot and left hip with weight-bearing at work. She authorized time loss and treated the right foot and ankle as well as the low back and left hip. By report dated December 2, 1988, Dr. Phillips indicated that the back pain had improved but that, due to continued ankle pain with weight-bearing, claimant could not yet return to work. (Ex. 25).[1]

By letter of December 9, 1988, the self-insured employer's processing agent declined to reopen the claim on the grounds that "medical information in your file indicates that your condition has not worsened since your claim was previously closed." Claimant did not request a hearing on the denial.

On February 20, 1989, claimant was released to light work with limitations on standing. Claimant actually returned to work in March 1989. Upon return to work, claimant had a recurrence of symptoms of low back and hip pain; Dr. Phillips again authorized time loss. Dr. Phillips explained that this period of time loss was due to low back and hip pain. (Ex. 42).

By letter of May 16, 1989, the self-insured employer's processing agent denied claimant's back and hip conditions on the ground that they are not related to the accepted right ankle condition. Claimant requested a hearing. The sole issue raised at hearing was the compensability of claimant's back and hip conditions. The Referee found that the conditions were compensable and remanded the claim for processing.

III.

I would approach the problem as follows.

The first denial addressed the claim for reopening. That denial did not deny any of the conditions which Dr. Phillips was then treating. It did not deny medical services for any of those conditions.[2]

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[1] Nothing in the record supports the panel's finding that this period of temporary disability was due to back and hip pain rather than to foot and ankle pain.

[2] It may be that the self-insured employer never paid the physician for her services. However, the record is not clear on this point. In any event, there is no evidence whatever that claimant knew that her treatment was not going to be covered.

The doctrine of claim preclusion provides that when a claim is litigated to final judgment, the judgment bars future litigation of that claim. For purposes of claim preclusion, a claim includes all claims arising out of the same transaction. Restatement of Judgments 2d, sections 19 and 24 (1980). Thus, failure to litigate an issue when a hearing is convened to litigate a second issue arising out of the same set of operative facts, bars future litigation of that issue. The related issue is deemed waived. See e.g., Million v. SAIF, 45 Or App 1097 (1980).

Additionally, failure to request a hearing on a denial precludes further assertion of that claim which was specifically denied. Liberty Northwest v. Bird, 99 Or App 560 (1989).

Whether a worker actually litigates a claim or forgoes it by failing to avail herself of the opportunity to litigate, she is foreclosed from asserting only claims which she knowingly waived. Drews v. EBI Companies, 310 Or 134 (1990); David M. Marvin, 42 Van Natta 1778 (1990).

The principle of fairness is at the heart of the waiver doctrine. In Drews v. EBI Companies, supra, the Court looked to what the claimant knew at the time of a prior hearing to determine whether the worker's failure to raise an issue concerning the rate of temporary total disability compensation at that time precluded him from later raising it. Finding that there was no basis in the record for concluding that claimant knew of the right to seek a correction in the rate of compensation at the time of the prior hearing, the Court concluded that the claimant could not have intentionally relinquished the right to the correction. Therefore, the Court held that the claim was not precluded by res judicata.

This fairness principle is illustrated in International Paper Company v. Pearson, 106 Or App 121 (1991). In that case, the parties had agreed that certain medical benefits were not compensable. Thereafter, claimant sought further services which were necessary by virtue of the same automobile accident which occasioned the earlier services. Because the first agreement addressed only a claim for specific medical services and did not address the condition itself, the later claim was not barred.

The question, then, when a worker has not challenged a denial of an aggravation claim within the time provided by statute and later seeks further compensation in the claim, is whether that worker has knowingly waived medical benefits for the condition that gave rise to the aggravation claim. The answer generally turns on the language of the denial. If the denial addresses entitlement to specific benefits but does not address a specific condition, then the denial cannot later be read to preclude the condition itself. If, on the other hand, the denial denies a specific condition, then the denial precludes not only reopening of the claim but also all future benefits for the denied condition.

The principle is one of fairness. If the employer clearly states that all compensation is denied for a particular condition, then the worker has received fair notice that she must act to preserve her right to medical services and other future compensation in the claim. If, however, the employer merely states that reopening is denied, then claimant has no reason to know that she must act to preserve her right to medical services for the condition.

To apply these principles to this case, we must begin with the proposition that it is the proponent's obligation to establish the elements of claim preclusion. Troutman v. Erlandson, 287 or 187 (1979). Thus, the self-insured employer must establish that, by allowing the aggravation denial to stand, claimant knowingly and intentionally waived her claim to medical services for

the left hip and back conditions. I am unable to find that she did. First, the December 9, 1988 denial identified the claim it addressed as a claim for reopening for aggravation. It did not mention claimant's left hip and back conditions, much less state that the conditions were not compensable. It did not state that claimant's then-current condition was not compensable. It did not state that claimant's medical services would not be paid. Second, claimant had no reason extrinsic to the denial to believe that the self-insured employer intended to deny specific conditions. At the time of the denial, claimant was receiving services for the accepted ankle condition as well as the hip and back conditions; so she would have had no reason to suspect that the denial was prompted by the identification of the new conditions. There was no medical evidence in the file addressing the compensability of the new conditions. Moreover, assuming the self-insurer had not reimbursed Dr. Phillips for her services, there is no evidence that claimant was advised of that fact. For these reasons, claimant could not have knowingly waived her right to contend that her left hip and back conditions were compensable by failing to challenge the aggravation denial. Thus, she is entitled to assert those claims in response to the self-insurer's May 16, 1989 denial of those conditions.

IV.

The panel, however, holds that claimant cannot contest the later denial of claimant's low back and hip conditions because she could have litigated that compensability issue at the time of the first denial. The panel suggests that the denial created an opportunity for litigation; that any claim which arose out of the same set of operative facts is therefore precluded; that the claim for a left hip and back condition arose out of the same set of operative facts as the claim for aggravation; and, thus, that claimant may not litigate the compensability of the left hip and back conditions unless they have changed since the issuance of the aggravation denial. This is error.

OAR 438-05-055 directs a worker to request a hearing on any denial that the worker contends is "not right." Presumably, then, the worker is charged with responsibility to read the denial carefully. Only if the worker is satisfied that the denial is wrong, should he request a hearing. Unlike this direct approach, the panel's approach to res judicata makes the workers' compensation system into a shadow boxing arena. The panel would require a worker to read the denial carefully and challenge it even if it is not wrong. Under this approach, a worker would be required to imagine what claims the insurer might later contend arose out of the same set of operative facts and request a hearing to protect a claim not yet formally denied.

The panel unnecessarily has made a monster of the requirement that a party simultaneously litigate all claims arising out of the "same set of operative facts." The Restatement instructs us to determine "pragmatically" what factual groups constitute a single transaction. The determination requires that we consider "such considerations as whether the facts are related in time, space, origin, or motivation, whether they form a convenient trial unit, and whether their treatment as a unit conforms to the parties' expectations or business understanding or usage." Restatement of Judgments 2d, supra, section 24(2). The panel's solution is not a pragmatic one.

A worker is entitled to lifetime medical services for conditions related to a compensable injury. ORS 656.245. It is not necessary, in order to receive such services after a claim is closed, that the claim be reopened for aggravation. To establish entitlement to additional medical benefits, only causal relation need be proven.

On the other hand, a worker is not entitled to additional temporary or permanent disability compensation, after claim closure, unless the claim is reopened. ORS 656.273; Gwynn v. SAIF, 304 Or 345 (1987).

Consequently, when an insurer declines to reopen a claim on the ground that the compensable condition has not worsened and does not also specifically deny medical services for claimant's condition, there is no reason to assume that medical services will also be denied. Indeed, it is common practice for workers to allow such denials to stand and yet to continue to file claims for medical services in the former of additional doctor bills. In other words, although the same conditions may give rise to claims for both medical services and for aggravation (disability compensation), a denial of the latter is not conventionally treated as a denial of the former.

This practice enables the workers' compensation system to run smoothly. It allows the worker to forgo denied claims without fear that, by so doing, the worker will also be giving up related but undenied claims.

To adopt the panel's broad definition of a "set of operative facts," for res judicata purposes, on the other hand, requires those unfortunate workers who interact with this workers' compensation system to be perpetually on guard against unarticulated denials. A denial of one type of compensation must be challenged lest the worker be deemed to have waived any other related claim. This approach is both unfair, in that it holds that a worker has waived rights that the worker did not know were at risk, and not pragmatic, in that it will force litigation where longstanding practice has not required it.

The better rule is that a claimant may allow a denial of an aggravation claim to stand, thereby giving up his claim to further disability compensation for the allegedly worsened condition, while retaining his right to litigate the questions of compensability of his then-current condition and entitlement to medical services therefor. Only if a denial explicitly denies both reopening and compensability of a condition and services therefor must claimant contest the denial to preserve his right to medical services for his condition. Such a view of what is a single transaction for res judicata purposes, is consistent with current practice and is in the interests of administrative economy.

V.

The panel has not applied the doctrine of claim preclusion correctly. The result is that claimant will be required to request hearings on aggravation denials which they are willing to let stand simply to eliminate the expansive preclusive effect the panel is willing to give such denials. Ordinary principles of res judicata do not require such action. Chavez v. Boise Cascade Corporation, 307 Or 632 (1989). Consequently, I dissent.

April 3, 1991 Cite as 43 Van Natta 827 (1991)

In the Matter of the Compensation of
WILLIAM L. STONE, Claimant
WCB Case No. 89-19292
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Garaventa's order that affirmed a Determination Order award of 29 percent (92.8 degrees) unscheduled permanent disability, 39 percent (58.5 degrees) scheduled permanent partial disability for the loss of the left forearm, and 38 percent (57 degrees) scheduled permanent partial disability for the loss of the right forearm. On review, the issue is extent of permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that the December 6, 1988 Determination Order had become final by operation of law, because claimant had failed to request a hearing within 180 days of its issuance. See ORS 656.268(6). Finding that claimant had also failed to prove a permanent worsening of his compensable condition since the time of that Determination Order, the Referee concluded that there was no justification for redetermining the extent of claimant's permanent disability.

On review, we agree with the Referee that claimant was required to request a hearing on the December 6, 1988 Determination Order, and that his failure to do so was not excused by the fact that his claim was subsequently reopened for his hand surgery. See Stepp v. SAIF, 304 Or 375 (1987). Consequently, we adopt the conclusions and reasoning concerning that argument as set forth in the Referee's order. We write separately, however, to address claimant's alternative argument not previously discussed.

Claimant contends that, although he failed to prove a worsening of his condition, he is entitled to a new determination of the extent of his disability because his vocational training program has now officially ended. He relies on ORS 656.268(5), which provides, in pertinent part:

> "If, after the determination made or notice of closure issued pursuant to subsection (3) or (4) of this subsection, the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, any permanent disability payments due under the determination shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Insurance and Finance shall redetermine the claim pursuant to subsection (4) of this section unless the worker's condition is not medically stationary."

Under that statute, when a worker enters an authorized training program after an initial determination of disability is made, payment of permanent disability benefits ceases and payment of temporary compensation begins. When the worker is no longer engaged in the training program, a redetermination of disability must be made unless the worker's condition is not medically stationary.

We agree with claimant that, under those circumstances, a worker is entitled to a new determination of his disability without regard to previous awards. Watkins v. Fred Meyer Inc., 79 Or App 521 (1986). Moreover, the worker need not show a worsening in his condition. Hanna v. SAIF, 65 Or App 649 (1983). In this particular case, however, claimant enrolled in an authorized training program in 1983. At that point, no initial determination of his disability had been made. In fact, the first rating of the extent of his disability came some five years later, when the December 6, 1988 Determination Order issued. Accordingly, ORS 656.268(5) does not apply. Thus, in order for claimant to obtain an additional award following the final Determination Order of December 6, 1988, he must establish a worsening of his condition. Claimant has not done so.

ORDER

The Referee's order dated March 8, 1990 is affirmed.

In the Matter of the Compensation of
VINCENT B. SWEENEY, Claimant
WCB Case No. 90-09754
ORDER ON RECONSIDERATION
Dennis O'Malley, Claimant Attorney
David J. Lillig (Saif), Defense Attorney

On March 14, 1991, we abated our February 20, 1991 Order on Review. We took that action in order to consider claimant's motion for reconsideration. Having received the SAIF Corporation's response, we proceed with our reconsideration.

This case arose when claimant entered an authorized training program shortly after a Determination Order had issued. Pursuant to ORS 656.268(5), SAIF suspended payments of the 36 percent permanent disability that had been awarded by the Determination Order, and replaced them with temporary disability payments. At the conclusion of the training program, SAIF reevaluated claimant's disability and issued a Notice of Closure, which awarded only 17 percent permanent disability. Although it had not challenged the original Determination Order, which had then become final by operation of law, SAIF maintained that it was only obligated to pay claimant the 17 percent permanent disability.

A hearing was held on July 20, 1990. The Referee concluded that SAIF was bound by the original Determination Order and ordered it to resume the suspended payments owed thereunder. However, the Referee further examined the permanent disability awarded under the Notice of Closure and concluded that claimant was entitled to an additional 8 percent. Therefore, he increased claimant's award from 17 percent to 25 percent and, from the increased compensation, awarded claimant's attorney 25 percent as a reasonable fee. He also awarded claimant a $300 attorney fee for SAIF's unreasonable claims processing.

On review, we agreed that SAIF was bound by the final Determination Order. While SAIF was entitled to reevaluate claimant's condition and close the claim, we held that it had no authority to reduce the final award of 36 percent disability. Because claimant sought no increase beyond that 36 percent, we further found that the Referee's 8 percent increase in compensation was moot. Consequently, we reversed the increased award and related attorney fee. We also affirmed the $300 penalty related attorney fee and awarded claimant's attorney $1,000 for services on Board review.

Claimant now requests reconsideration of hearing level attorney fees. He contends that his attorney was instrumental in obtaining an additional $6,800 in benefits -- the difference between the 17 percent disability awarded by the Notice of Closure and the 36 percent disability awarded by the Determination Order -- yet will receive only $300 for his services at the hearing level under our Order on Review. Claimant asks the Board to award $1,622.50 as a reasonable attorney fee to be paid by SAIF for its unreasonable resistance to payment of compensation. In the alternative, he requests a fee of 25 percent of the increase in compensation. We deny both requests.

First, contrary to claimant's belief, his attorney did not obtain an increase in compensation at the hearing level. Claimant was originally awarded 36 percent permanent disability by the unappealed and final Determination Order. At hearing, he did not obtain an increase in compensation above that award, but rather secured the resumption of payments owed thereunder. Therefore, an attorney fee based on an increase in compensation would not be appropriate.

Second, claimant has already been awarded an attorney fee for SAIF's unreasonable claims processing. Evidently, claimant now contends that the amount

awarded was inadequate. However, claimant did not raise or argue that issue on review. We decline to entertain issues raised in the first instance on reconsideration. See e.g. James D. Tate, 42 Van Natta 112 (1990).

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BERT W. UDELL, Claimant
WCB Case No. 86-09647
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Howell, Speer and Crider.

The SAIF Corporation requests review of Referee Myers' order which set aside its denial of claimant's occupational disease claim for a bilateral hip condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has been self-employed doing timber cruising, property appraisals, consulting and operating tree farms for the last forty years. These jobs have required him to be on his feet a majority of the time. He has had to walk over all types of terrain as well as climb and jump over various obstacles.

Claimant first began developing hip symptoms in the late 1960's. He would experience aching and soreness after actively using his legs. At that time, his symptoms were worse in the left hip. At various times, he sought medical treatment and was treated with anti-inflammatories.

In early 1986, claimant consulted with Dr. Neumann, surgeon, for increasing symptoms in his hips. In February 1986, Dr. Neumann performed a total left hip arthroplasty. Thereafter, claimant filed a claim for bilateral hip joint problems. In April 1986, Dr. Neumann performed a total right hip arthroplasty. In June 1986, SAIF denied claimant's claim.

Claimant is 67 years of age and has degenerative arthritis in both hip joints. Claimant also suffers from moderate exogenous obesity.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work activities were the major contributing cause of his bilateral hip condition. We disagree.

In an occupational disease setting, where multiple causes combine to produce one indivisible disease, it is claimant's burden to prove that his work activities were the major contributing cause of either the onset or the worsening of his underlying condition. Former ORS 656.802(1)(a); Runft v. SAIF, 303 Or 493, 498 (1987); Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983). In determining whether claimant has met the burden of proving that work conditions were the major contributing cause of a disease, we compare employment conditions

to non-employment conditions, explanations or exposures. David K. Boyer, 43 Van Natta 561 (1991).

The issue of whether claimant's work activities is the major contributing cause of his bilateral hip condition is a complex medical question. Therefore, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Dr. Neumann, claimant's treating surgeon, initially indicated that although he could not directly relate claimant's bilateral hip condition to his job activities, he could not rule out the job activities as a contributing factor. Dr. Neumann later wrote to claimant's counsel indicating that claimant's work activities were the major contributing cause of claimant's bilateral hip condition.

Claimant was also examined by Dr. Becker, an orthopedist, and Dr. Montanaro, a rheumatologist. Dr. Becker reported that claimant had bilateral hip degenerative joint disease and moderate exogenous obesity. He opined that no single factor could be implicated as the major contributing cause of claimant's bilateral hip condition. Dr. Becker concluded that claimant's condition appeared to be a case of degenerative arthritis of a spontaneous, progressive type, associated with aging. Dr. Neumann concurred with Dr. Becker's report.

Finally, Dr. Montanaro opined that claimant's work activities contributed to his hip condition, but were not the major factor. He further opined that there was no one contributing factor that would be considered the major cause, but a combination of age, genetic predisposition and obesity should be considered as having a greater contribution than claimant's work activities.

When medical evidence is divided, we tend to give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, although all of the medical evidence suggests that claimant's work activities contributed to his bilateral hip condition, the only medical opinion which finds that the activities were the major cause is Dr. Neumann's letter to claimant's counsel. Although Dr. Neumann is claimant's treating surgeon, we do not find his opinion persuasive.

Dr. Neumann initially reported that he could not directly relate claimant's work activities to his bilateral hip condition. Thereafter, he concurred with Dr. Becker's opinion that claimant's work activities were not the major contributing cause of the condition. In his last report, however, Neumann opines that claimant's work activities were the major contributing cause of his bilateral hip condition. Dr. Neumann provides no explanation for his change in opinion, therefore we do not find his opinion persuasive. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Under these circumstances, we conclude that claimant has failed to establish that his work activities, in comparison with nonwork-related conditions, were the major contributing cause of his bilateral hip condition.

ORDER

The Referee's order dated November 12, 1987 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's award of an $1,800 assessed attorney fee is reversed.

Board Member Crider, dissenting.

I would find that work activities were the only activities or exposures that played a part in the development of claimant's condition. I would affirm the Referee's order for the reasons stated therein as well as my dissenting opinion in David K. Boyer, supra.

The majority makes no finding as to whether or not claimant's work activity made any contribution at all. If the majority finds, based on record, evidence that work activity played no part at all in the development of claimant's condition, then, of course, the claim is not compensable. However, there is also medical opinion supporting the view that work activity along with age, genetic predisposition and obesity caused the condition but that the latter three causes combined made a greater contribution to the causation of the disease than did working conditions. If the majority relies on that evidence, then the outcome depends on the legal issues discussed in David K. Boyer, supra.

April 4, 1991 Cite as 43 Van Natta 832 (1991)

In the Matter of the Compensation of
MIKE K. BARRERAS, Claimant
WCB Case No. 89-15758
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Fink's order which: (1) admitted a post-hearing deposition (Exhibit 13) into the record; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 22 percent (70.4 degrees), as awarded by Determination Order, to 32 percent (102.4 degrees). The SAIF Corporation cross-requests review contending that the Referee's increase of unscheduled permanent disability should be reversed. On review, the issues are admission of evidence and extent of unscheduled permanent disability. We exclude Exhibit 13 and modify the Referee's order.

FINDINGS OF FACT

In November 1988, claimant sustained a compensable injury to his low back. At the time of his injury, he was employed as an orchard manager responsible for the production on 500 acres. His duties included supervising two lead workers as well as supervising other workers involved in caring for the orchard. Prior to his injury, claimant had worked for the employer for approximately 20 years. The last ten years he had worked as a foreman, administrative assistant and orchard manager.

Claimant's claim was closed by an August 7, 1989 Determination Order which awarded him 22 percent unscheduled permanent disability. He was found to be medically stationary as of June 8, 1989.

Claimant is 42 years old and has an eleventh grade education. He is unable to return to his usual and customary work which required medium capacity. As a result of the compensable injury, he is now limited to sedentary work.

As a result of his compensable injury, claimant's thoracolumbar flexion is limited to 45 degrees. His thoracolumbar extension is 10 degrees and his thoracolumbar right and left flexion are both 25 degrees. He can no longer perform any repetitive bending, twisting or squatting.

At hearing, SAIF submitted two documents (exhibits 11 and 12) from Dr. Rutter, which had not been disclosed prior to hearing. The Referee allowed admission of the documents, but permitted a continuance in order for claimant to depose Dr. Rutter. Two days following the hearing, claimant informed the Referee that he was waiving his right to depose Dr. Rutter. Thereafter, SAIF requested that it be allowed to depose Dr. Rutter. The Referee allowed SAIF to depose Dr. Rutter and then admitted the deposition into the record.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

Claimant contends that the Referee erred in admitting Dr. Rutter's post-hearing deposition into the record. We agree.

OAR 438-07-018(4) allows the Referee discretion to admit evidence not disclosed pursuant to OAR 438-07-015. OAR 438-06-091 provides that parties shall be prepared to present all their evidence at the scheduled hearing, but allows for continuances under specified circumstances. Finally, OAR 438-07-023 provides that, "the party bearing the burden of proof on an issue in a hearing has the right of first and last presentation of evidence and argument on the issue."

Here, SAIF's submission of Exhibits 11 and 12 was untimely. The Referee admitted these exhibits, but left the record open in order to allow claimant the opportunity to cross-examine Dr. Rutter, the author of the exhibits. Two days following the hearing, claimant's counsel notified the Referee that he did not wish to cross-examine Dr. Rutter and asked that the record be closed. Thereafter, SAIF's counsel asked to depose Dr. Rutter. This request was granted and Dr. Rutter's deposition was admitted into the record as Exhibit 13.

We find that the Referee erred in admitting Exhibit 13. Claimant had the burden of proving extent of disability, therefore, pursuant to OAR 438-07-023, had the right of last presentation of evidence. The admission of Exhibit 13 was in contravention of this provision and allowed SAIF to present the last evidence. Moreover, SAIF had already submitted documentary evidence from Dr. Rutter. Therefore, to permit SAIF to develop further evidence from Dr. Rutter, after the hearing, would also effectively circumvent OAR 438-06-091 by allowing for a continuance without being subject to the strictures of that provision.

Under these circumstances, we conclude that the Referee abused his discretion in admitting Exhibit 13 into the record. Accordingly, Exhibit 13 is excluded from the record and we do not consider it on review.

Extent of Permanent Disability

The Referee concluded that claimant has sustained unscheduled permanent disability equal to 32 percent as a result of his compensable low back injury. We modify.

The parties do not dispute the values assigned by the Referee for claimant's age, education, skills and impairment. Therefore, we adopt the above mentioned values when we calculate claimant's permanent disability under the standards and discuss only the value for training and adaptability.

Age.

The appropriate value for claimant's age of 42 years is +1. Former OAR 436-35-290.

Formal education.

The appropriate value for claimant's 11 years of formal education is +1. Former OAR 436-35-300(3).

Skills.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of hearing is used to determine a value for skills. See Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of hearing was 7 as a orchard supervisor (DOT # 403.131-010). Therefore, the appropriate value for skills is +1. Former OAR 436-35-300(4).

Training

Former OAR 436-35-300(5) provides for a value of +1 for workers who do not have competence in a specific vocational pursuit. "Specific vocational pursuit" means employment other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Here, claimant had 10 years of training as a foreman, administrative assistant and manager of an orchard which we conclude provides him with competence in a position other than an entry level position. Claimant is therefore not entitled to a value for training.

Claimant's total education value is +2, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular, modified work since he became medically stationary (when permanent disability is rated). Claimant's physical capacity falls within the sedentary category. Thus, the appropriate adaptability value is +8. Former OAR 436-35-310(4)(d). In reaching this conclusion, we rely on the May 1989 physical capacities report from Dr. Rutter, the treating physician.

Impairment

Claimant's lost range of motion (9 percent) and chronic limited repetitive use of his back (5 percent) is combined to give claimant a total impairment value of 14 percent. Former OAR 436-35-320(2).

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value +1 is added to his education value +2 the sum is +3. When that value is multiplied by claimant's adaptability value +8 the product is +24. When that value is added to claimant's impairment value 14 the result is 38 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

Consequently, claimant's award is increased from 32 percent to 38 percent unscheduled permanent disability.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning SAIF's request to reduce permanent disability is $800, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 29, 1990 is modified. In addition to the Referee's Award and Determination Order award of unscheduled permanent disability, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability for a total award of 38 percent (121.6 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order. However. the total approved attorney fee awarded by the Board and Referee order shall not exceed $3,800. For services on review concerning SAIF's request to reduce permanent disability, claimant's counsel is awarded an assessed attorney fee of $800, payable by the SAIF Corporation.

April 4, 1991 Cite as 43 Van Natta 835 (1991)

In the Matter of the Compensation of
EDWIN L. CARSON, Claimant
WCB Case No. 89-08904
ORDER ON RECONSIDERATION (REMANDING)
David Schieber (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our January 23, 1991 order, which vacated the Referee's order and remanded the case to the Referee to determine whether claimant understood and agreed to the terms of a stipulation agreement in which claimant withdrew his request for hearing on the compensability of his occupational disease claim. Specifically, SAIF contends that as claimant was represented by counsel at hearing, he is bound by the actions of his attorney, and it is irrelevant whether claimant understood and agreed to the terms of the stipulation. On February 21, 1991, we abated our order to allow sufficient time to consider SAIF's motion and to give claimant an opportunity to respond. The time to respond having expired and having completed our further consideration of the matter, we now proceed to our review.

Citing James N. McGrew, 43 Van Natta 313 (1991), SAIF contends that if claimant is dissatisfied with the stipulation agreement, his recourse is to bring a malpractice action against his attorney rather than seek remand and a hearing. In McGrew, supra, the claimant was unable to appear for his hearing and his attorney proceeded without him. This case is distinguishable because unlike the claimant in McGrew, this claimant received no hearing and no record was created.

The Board has discretionary authority to remand cases such as this one, when, in its judgement, it finds the record to be improperly, incompletely, or otherwise insufficiently developed. Schultz v. St. Compensation Dept., 252 Or 211 (1968); James Leppe, 31 Van Natta 130 (1981).

We have previously found that the record in this case is incompletely and otherwise insufficiently developed, as there is no record other than the Referee's brief comments and the attorney's statement. Former 656.295(3) and (5).

Moreover, the Board is not vacating the Order on Stipulation. Rather, this case is being remanded to Referee Brown for creation of a record from which to evaluate the circumstances surrounding the formulation of the stipulation agreement.

Under these circumstances, we continue to conclude that remand is proper. Accordingly, we withdraw our January 23, 1991 order. On reconsideration, we adhere to and republish our January 23, 1991 order, as supplemented herein. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN K. FRENCH, Claimant
WCB Case No. 90-04883
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers, Cushing and Crider.

The self-insured employer requests review of Referee Brown's order that: (1) set aside its "back-up" denial of claimant's low back injury claim; and (2) assessed a penalty and related attorney fee for its allegedly unreasonable "back-up" denial. On review, the issues are the propriety of the employer's denial and penalty and attorney fees. We affirm.

FINDINGS OF FACT

In 1966, claimant injured his back in a motor vehicle accident. He experienced back symptoms for several months but had full recovery. In 1986, claimant sought treatment for right shoulder and right knee pain at a Veterans' Administration Medical Center. At that time, he also complained of low back pain and received conservative treatment on two occasions. On August 9, 1989, he again sought treatment for low back pain from Dr. Damond, a chiropractor. The pain was related to a move; it resolved.

On October 25, 1989, claimant injured his low back while working as a drill press operator for the employer. He returned to Dr. Damond, who diagnosed a lumbrosacral sprain with sciatic neuralgia. He was later referred to Dr. Peterson, who also diagnosed a lumbosacral strain. Dr. Peterson believed that claimant had a nerve root irritation.

The employer first knew of the injury on November 8, 1989. On November 10, 1990, claimant filed an 801 form seeking compensation for a low back strain. The box asking "has body part been injured before" was left unanswered. On December 4, 1989, the employer received Dr. Peterson's 827 Form, on which claimant had checked the box "no" in response to the question "has body part been injured before."

On December 5, 1989, the employer accepted the claim as a nondisabling injury. That same day, it received a copy of Dr. Damond's chart notes, which indicated that claimant had sought treatment for low back pain in August 1989. On January 24, 1990, the employer received a report from Dr. Woolpert, IME, which revealed that claimant had suffered an automobile accident and back injury in 1966. Later, on February 1, 1990, the employer received notice of claimant's low back treatment at the VA Medical Center.

On February 22, 1990, the employer denied the previously accepted claim on the ground that claimant had misrepresented his condition when he failed to disclose his prior low back problems. Claimant filed a request for hearing, which was received and acknowledged by the Board on March 5, 1990. A hearing was initially set for July 25, 1990. However, on June 1, 1990, the Board mailed a notice of accelerated hearing to all parties involved and reset the hearing for June 25, 1990. A hearing was convened on that date before Referee Emerson, and was later continued before Referee Brown on July 25, 1990.

FINDINGS OF ULTIMATE FACT

Claimant requested a hearing on SAIF's denial before May 1, 1990; the hearing was convened before July 1, 1990.

Claimant did not misrepresent any material fact that could have induced the employer to accept the claim.

Claimant suffered an injury at work on October 25, 1989, which was a material contributing cause of his subsequent disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

Referee Brown first concluded that the Board was within its authority to convene a hearing in this case on June 25, 1990 and, therefore, concluded that this matter was subject to the "old" law. He then found that claimant's failure to disclose his prior low back treatment was not sufficiently "material" to reasonably affect the employer's decision to accept the claim. Accordingly, the Referee concluded that the employer was bound by its acceptance issued on December 5, 1989, and that the February 22, 1990 attempt to deny the claim was an impermissible "back-up" denial under Bauman v. SAIF, 295 Or 788 (1988).

Applicable Law

On review, the employer first challenges the applicability of the Bauman rule. It contends that this case is subject to the new law effective July 1, 1990, which, among other things, modified the Bauman rule on retroactive denials. See Or Laws 1990 (Special Session), ch 2, 15. We disagree.

According to 54, paragraph (1) of the 1990 Act, the general rule is that the new law applies to all claims existing or arising on or after July 1, 1990, regardless of the date of injury. However, 54, paragraph (2) provides that a claim for which a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined under the old law, that is, the law in effect before July 1, 1990. In this case, claimant's request for hearing was received on March 5, 1990, and a hearing was convened on June 25, 1990. Accordingly, the new law does not apply.

The employer next challenges the legality of the Board's actions. It contends that the Board lacked statutory authority to accelerate the date of hearing and convene this case before July 1, 1990. We disagree.

Under ORS 656.726(2), the Board is charged with overall responsibility for the Hearings Division. This plainly includes the authority to set and schedule hearings. See ORS 656.726(2)(a), (d). The statutory framework does require that a request for hearing be referred to a Referee for determination as expeditiously as possible, and that a hearing be scheduled for a date not more that 90 days after the receipt by the Board of the request for hearing, except in extraordinary circumstances. ORS 656.283(4). However, we find no statutory provision that prohibits the Board from rescheduling or accelerating the date of a

hearing, provided that it give 10 days prior notice of the time and place of hearing to all parties in interest by mail. See ORS 656.283(5).

In this case, the Board mailed a notice of the accelerated hearing on June 1, 1990, advising the parties that the hearing would be convened on June 25, 1990. The employer does not contend that it had insufficient notice of the hearing. To the contrary, it acknowledged that such notice was sent and evidently was received. (Tr. 2). Accordingly, we conclude that the acceleration of the date of hearing was within the Board's statutory authority.

The employer argues that, even if the Board had authority to convene this case on June 25, 1990, the proceeding held that day was insufficient to constitute a convened hearing. It maintains that the event was procedurally flawed, because no testimony was given, no evidence was submitted and the merits of the case were not discussed.

The terms "hearing" and "convene" are not defined by the Oregon Workers' Compensation Act. Generally, a "hearing" contemplates activities that the employer has mentioned, that is, the presentation of evidence, subject to cross-examination, and the litigation of the merits. See Davis, Administrative Law 7.01 (West 3d ed 1972). However, for our purposes, the proper inquiry is not whether a hearing was held on June 25, 1990, but rather whether a hearing was duly convened.

As noted above, "convene" is not statutorily defined. We therefore construe the term in accordance to its customary meaning. Fletcher v. SAIF, 48 Or App 777 (1980). "Convene" is legally defined as "to call together; to cause to assemble; to convoke." Black's Law Dictionary 175 (West, 5th ed 1983). Similarly, "convene" is commonly defined as "to call together * * * to summon before a tribunal etc." Webster's Encyclopedic Dictionary, 213 (Lexicon, 1983).

There can be little doubt that, under the circumstances, the parties in this case were called together before a tribunal. The Board mailed a "Notice of Accelerated Hearing" to claimant, his attorney and the employer on June 1, 1990. The notice served as a summons to appear before a Referee, and advised them of the time and place of hearing. Moreover, the notice conformed with ORS 656.283(5), and was an attempt for the Board to meet its statutory directive to hold a hearing within 90 days of claimant's request.

It also is clear that the proceeding held on June 25, 1990, was procedurally legal and proper. Referee Emerson opened the record and officially recognized that the parties were present or, in the alternative, that the parties had received legal notice and waived appearance. In addition, contrary to the employer's allegation, claimant's counsel waived a reading of the "Notice to Parties of Rights and Procedures in Workers' Compensation Cases," as required under the Oregon Administrative Procedures Act. See ORS 183.413.

Accordingly, we conclude that, on this record, a hearing was duly convened on June 25, 1990. The question remains, however, whether it was proper to continue the hearing at a later date.

Generally, continuances are disfavored. OAR 438-06-091. Nonetheless, a Referee may continue a hearing for further proceedings if the time allocated for the scheduled hearing is insufficient to allow the parties to present their evidence and argument. OAR 438-06-091(1). A continuance also is allowed for any reason that would justify a postponement of a scheduled hearing under OAR 438-06-081, which provides that "[a] scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties[.]" We find both justifications present here.

In this case, claimant filed a request for hearing on February 28, 1990. The request was received and acknowledged by the Board on March 5, 1990. Ordinarily, a hearing should have been scheduled for a date not more than 90 days after March 5, 1990. See ORS 656.283(4); former OAR 438-06-020. However, a hearing was not initially scheduled until July 25, 1990.

Before claimant's hearing was held, the Oregon Legislature enacted an extensive revision of Oregon's Workers' Compensation Act. Or Laws 1990 (Special Session). The new law was to become effective July 1, 1990, and essentially would apply to all claims except those for which a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990.

In light of the legislative action, and in an attempt to offset its failure to schedule a hearing within 90 days of claimant's request for hearing, the Board accelerated the scheduled date of hearing in this and other similarly situated cases. Consequently, as noted above, a hearing was duly convened on June 25, 1990.

Due to the number of cases scheduled for that day, the parties were unable to present their evidence and argument during the time allocated for each hearing. Thus, on that basis alone, we believe that Referee Emerson was justified in continuing the hearing. Furthermore, we also find that the situation described above constitutes extraordinary circumstances beyond the parties control, warranting a continuance of this matter.

Back-up Denial

The employer finally contends that, even if the Bauman rule applies, the Referee erred in finding that claimant's failure to disclose his prior low back treatment was not sufficiently "material" to justify a "back-up" denial. We disagree.

Under Bauman v. SAIF, supra, an employer may not deny a previously accepted claim more than 60 days after notice or knowledge of the claim unless the employer establishes both that the claimant materially misrepresented a material fact and that the misrepresentation reasonably could have affected the insurer's decision to accept the claim. Ebbtide Enterprises v. Tucker, 303 Or 459 (1987). If the employer meets its burden, then it becomes claimant's burden to establish that the claim is in fact compensable.

We agree with the Referee's conclusion that, assuming that claimant misrepresented his medical history, the misrepresentation could not reasonably have affected the employer's decision to accept the claim.

The employer accepted the claim based on the Form 801, the Form 827, Dr. Peterson's chart notes, and a radiology report. None of these items discuss claimant's history regarding back pain at all. Thus, it is evident that no misrepresentation of any history of pain played any part in the acceptance of the claim. Nevertheless, claimant did deny any prior back injury on the Form 827. This misrepresentation, however, could not have led to the acceptance of a claim that otherwise would have been rejected. For if the employer had known of the 1966 injury and investigated it, the employer would have discovered that the injury resolved within months and that claimant suffered no back pain for decades thereafter. Thus, we conclude that claimant misrepresented no material fact that could reasonably have affected the decision to accept the claim. See e.g., Ebbtide Enterprises v. Tucker, supra.

The employer has failed to meet its burden of proof, and the back-up denial must be set aside.

Compensability

Assuming, however, that the employer did meet its burden under Bauman, we would conclude that claimant has established a compensable claim on the merits.

To establish a compensable injury, claimant must prove that he suffered an injury at work which was the material contributing cause of disability or need for treatment. It is sufficient that he establish that his workplace injury caused an asymptomatic condition to become symptomatic.

Claimant credibly testified that he experienced an onset of pain connected with a discrete incident at work. Dr. Damond, who was aware of claimant's August 9, 1989 symptoms, diagnosed a work-related sprain injury. He prescribed treatment. Although later advised of claimant's treatment at the VA, Dr. Damond did not alter that diagnosis. Moreover, Dr. Peterson, M.D., who also treated claimant, stated, based on a complete history supplied by counsel for the employer, that the at-work injury of October 25, 1989 was a material contributing cause of claimant's increased back symptoms. On the basis of these reports, we find that claimant's workplace injury was a material contributing cause of his disability and need for treatment.

In so doing, we discount the opinion of Dr. Woolpert, M.D., who performed an independent medical examination for the employer. We find no reason not to give greater weight to the opinions of claimant's treating physician than to that of Dr. Woolpert, who examined claimant only once and who performed that examination after the flareup of pain had passed.

Thus, we find the claim compensable.

Penalties and Attorney Fees

We adopt the conclusions and reasoning concerning the penalty and related attorney fee issue as set forth in the Referee's order.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $750 is a reasonable assessed fee for claimant's counsel's efforts concerning the issues on review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues presented, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for defending on the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated August 24, 1990 is affirmed. For services on Board review, claimant's attorney is awarded $750, to be paid by the self-insured employer.

In the Matter of the Compensation of
DANA LAUZON, Claimant
WCB Case No. 90-11329
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee Thye's order that set aside its denial of claimant's occupational disease claim for a stress-related mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant filed a hearing request on May 25, 1990 and the hearing was convened on September 7, 1990.

CONCLUSIONS OF LAW AND OPINION

The Referee applied ORS 656.802, as amended effective July 1, 1990. This is the correct law given the fact that the hearing request was filed after May 1, 1990, and the hearing was convened after July 1, 1990. See Oregon Laws 1990, (Special Session) Chap. 2, Section 54 (1) and (2). The Referee concluded that claimant met her burden of proof under ORS 656.802. We disagree.

Pursuant to ORS 656.802(1)(b), (2), and (3), to establish an occupational disease for a mental disorder, claimant must prove that: (1) the employment conditions were the major contributing cause of her mental disorder or its worsening; (2) the existence of the mental disorder or its worsening is established by medical evidence supported by objective findings; (3) she has a mental or emotional disorder which is generally recognized in the medical or psychological community; (4) she required medical services or was disabled; (5) the mental disorder was due to employment conditions which were real and objective; (6) such employment conditions are not generally inherent in every working environment and did not involve reasonable disciplinary, corrective or job performance evaluation actions or cessation of employment; and (7) the evidence is clear and convincing that the mental disorder arose out of and in the course of employment. If claimant fails to establish any one of these elements, her claim for a stress-related occupational disease fails.

The Referee relied on the opinion of Dr. Tongue, Ph.D., who treated claimant for her mental disorder. Dr. Tongue opined that prolonged hours in a small, windowless space in isolation from her co-workers was the primary source of claimant's emotional distress. The Referee concluded that Dr. Tongue's opinion establishes that the work environment was the major contributing cause of claimant's mental disorder. We disagree.

Neither of Dr. Tongue's two brief opinions addresses claimant's off-work stressors. The record contains evidence that claimant experienced off-work stress in that a worker was seriously injured in January 1990 in a tree topping business co-owned by claimant and her husband. Although claimant testified that she told all the doctors about everything, Dr. Tongue did not reference any off-work stressors. Where the opinions of a physician are based on an incomplete and inaccurate history, we do not find them persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, 64 Or App 810 (1983). Even though Dr. Tongue's opinions are uncontroverted, they do not

establish that work was the major contributing cause of the onset or worsening of claimant's mental disorder.

Nor does the record otherwise establish this element of proof. Dr. Parvaresh, examining psychiatrist, expressed no opinion as to the cause of claimant's condition. Dr. Edwards, clinical psychologist, examined claimant in the capacity of an Employee Assistance Program (EAP) counselor. He initially indicated that work was not the cause of claimant's condition, but a factor, and he recommended that she not return to her former position because of the work environment. (Ex. 5). However, he later deferred to the initial care provider. (Ex. 7-1). Even if this equivocation did not effect the persuasiveness of his opinion, we do not find that Edwards' statement that the work was "a factor" reaches the level of proof required to prove that work was "the major contributing cause" of claimant's mental disorder.

Claimant, therefore, has not proven that the work environment was the major contributing cause of her mental disorder, and for this reason her claim is not compensable. We do not address the remaining elements of proof under ORS 656.802(1)(b), (2) and (3), other than to note that we find no evidence in this record that the employment conditions were not generally inherent in every working situation.

Accordingly, we conclude the claim is not compensable and we reverse the Referee's contrary ruling.

ORDER

The Referee's order dated October 11, 1990 is reversed. The insurer's denial is reinstated and upheld. The Referee's $1,500 assessed attorney fee is reversed.

April 4, 1991 Cite as 43 Van Natta 842 (1991)

In the Matter of the Compensation of
DALE L. LOEFFLER (Deceased), Claimant
WCB Case No. TP-91007
THIRD PARTY ORDER OF DISMISSAL
Pozzi, et al., Claimant Attorneys
Todd C. Ainsworth, Defense Attorney

Arlene M. Loeffler, as personal representative of the deceased worker's estate (hereafter "claimant"), petitioned the Board for an order directing the paying agency to "'formally' and in written form" approve proposed third party settlements involving the deceased worker's estate. In response, the paying agency asserts that, since the value of the settlements is reasonable, it has endorsed them. However, the paying agency continues to dispute claimant's proposed allocation of the settlements' proceeds under the wrongful death statutes. Since the proposed distribution is currently pending before the Probate Court awaiting the paying agency's approval of the settlements, the paying agency agrees with claimant that the appropriate forum to resolve the issues regarding the specific allocation of proceeds likewise currently rests with the Probate Court.

Inasmuch as the paying agency has approved the third party compromises insofar as they pertain to the value of the settlements and because the parties agree that the appropriate forum to resolve their remaining dispute over the distribution of the settlements' proceeds is the Probate Court, we conclude that no conflict currently exists for our resolution. Accordingly, the petition for third party relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD L. MAY, Claimant
WCB Case No. 89-19746
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Peter O. Hansen, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Michael V. Johnson's order which declined to increase the rate of claimant's temporary disability compensation. On review, the issue is res judicata. We affirm.

FINDINGS OF FACT

With the exclusion of the third paragraph on page 2, we adopt the Referee's "Findings of Fact" with the following supplementation.

On August 17, 1988, claimant filed a request for hearing raising the issue of the SAIF Corporation's alleged failure to pay temporary disability compensation. Matters raised in the request for hearing were disposed of by means of a settlement stipulation approved by a referee on October 12, 1988. On October 12, 1988, claimant filed a request for hearing alleging that his temporary disability compensation was being paid at an incorrect rate. Referee Emerson held that, by virtue of the October 12, 1988 stipulation, claimant was barred from litigating the rate of compensation paid before October 12, 1988, but not afterward. Referee Emerson proceeded to evaluate the merits of the issue of claimant's temporary disability compensation after October 12, 1988 and found that claimant was not entitled to more compensation. Claimant requested Board review of Referee Emerson's order on March 22, 1989.

On review, the sole issue was claimant's temporary disability compensation rate. The Board issued its Order on Review on July 5, 1990 concluding that the October 12, 1988 stipulation did not bar claimant from raising the "issue" of his temporary disability compensation rate prior to October 12, 1988 because that "issue" had never been actually litigated to a final judgment. However, the Board affirmed Referee Emerson's determination on the merits of claimant's temporary disability compensation rate. That determination necessarily required resolution of the issue of claimant's "wage" on the date of injury. Claimant timely filed an appeal.

On October 4, 1989, claimant filed a request for hearing challenging SAIF's calculation of his temporary disability rate after January 20, 1989. A hearing was scheduled to convene in January, 1990. Meanwhile, the Employment Division, Hearings Section, issued a referee's decision on October 23, 1989, and a subsequent Appeals Board decision on November 17, 1989, concluding that claimant's hourly wage rate was higher than the rate determined by Referee Emerson.

CONCLUSIONS OF LAW AND OPINION

The Referee in the present case concluded that the doctrine of res judicata, specifically issue preclusion, bars claimant from relitigating the issue of his temporary disability compensation rate. We agree.

The term "res judicata" has been utilized to refer to the preclusive effect on a claim ("claim preclusion") and on an issue ("issue preclusion"). North Clackamas School Dist. v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Issue preclusion bars "relitigation of issues actually litigated and

determined, if their determination was essential to the prior order." Id.; see Drews v. EBI Companies, 310 Or 134 (1990).

In the present case, claimant attempts to relitigate the issue of the rate of his temporary disability compensation. The fact that he requests review of the rate as it affects a new pay period does not change the fact that it is the same rate issue as litigated before. Nor does the discovery of a new evidentiary fact, the Employment Division's decision, alter the preclusionary effect of the rule. We are still dealing with the same parties and the same necessary issue -- claimant's temporary disability compensation rate. See Drews v. EBI Companies, supra. We note that claimant's challenge is to the initial determination of his temporary total disability rate under ORS 656.210 (i.e., his wages on the date of injury). There is no issue regarding incremental increases provided for in ORS 656.210(1).

Even though claimant's appeal of the Board's Order on Review reviewing Referee Emerson's Opinion and Order is pending, the Board's Order on Review is final for purposes of res judicata/issue preclusion. This is particularly true because the Court of Appeals evaluates the substantiality of supporting evidence in the record -- it does not perform a de novo review of the evidence. Younger v. City of Portland, 305 Or 346 (1988); Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). Because the court will only evaluate whether there is substantial evidence to support the Board's temporary disability compensation rate finding, the required finality for issue preclusion is not affected by claimant having filed an appeal. See Restatement, (Second) of Judgments 13, comment f, p. 135 (1980).

Therefore, a valid, final judgment has been rendered with regard to the issue of claimant's temporary disability compensation rate. Claimant is barred from relitigating the issue. If claimant is to obtain another result it must be through reversal of the judgment on appeal.

ORDER

The Referee's order dated May 16, 1990 is affirmed.

April 4, 1991 Cite as 43 Van Natta 844 (1991)

In the Matter of the Compensation of
BETTY J. SMITH-SANDERS, Claimant
WCB Case No. 89-18180
ORDER ON REVIEW
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of those portions of Referee Fink's order which: (1) set aside its denial of knee surgery; and (2) assessed a penalty and attorney fee for an allegedly unreasonable denial. Claimant cross-requests review of those portions of the Referee's order which: (1) upheld the employer's denial of a right knee condition; (2) did not assess a penalty and attorney fee for an allegedly late denial; and (3) did not award an attorney fee for claimant's prevailing on an issue of entitlement to temporary disability. On review, the issues are medical services, compensability, penalties and attorney fees.

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

Claimant sought authorization for the knee surgery in July 1989. The employer informed both claimant and her surgeon that it was authorizing the surgery. After being informed that the employer was authorizing the surgery, the surgeon performed surgery on August 4. The employer denied the surgery (and the underlying knee condition) on December 12, 1989.

We agree with the Referee that the underlying knee condition is not compensable. The Referee found the knee surgery compensable as diagnostic surgery because the employer had authorized the surgery. The Referee was apparently applying estoppel to the employer. We do not agree that the surgery is compensable as diagonstic surgery, but we agree that the employer is estopped from denying the surgery.

In Lamarr H. Barber, 43 Van Natta 292 (1991), we held that equitable estoppel may be applicable against an insurer (or self-insured employer) if all the elements of estoppel are met. In Barber, we remanded to the Referee to develop the record to determine if the elements of equitable estoppel had been met because the Referee had refused to allow evidence on that question. In this case, on the other hand, the evidence is in the record to decide whether the employer should be equitably estopped from denying the surgery.[1] On this record, we conclude that the employer is so estopped.

The elements of equitable estoppel are: (1) a false representation; (2) made with knowledge of the facts; (3) where the other party is ignorant of the truth; (4) made with the intention that the other party will rely upon it; and (5) the other party must be induced to act upon the false representation. Barber, supra at 293.

Here the employer falsely represented that it was authorizing the surgery when it ultimately denied the surgery--a fact only it could have known. Claimant could not have known that the authorization would be denied. The fact that the employer told the doctor that the surgery was authorized evidences an intention that claimant and the doctor rely on the false authorization. Finally, the fact that claimant and the doctor proceeded with the surgery convinces us that claimant relied on the false representation that the surgery was authorized.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the medical services issue is $600, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 8, 1990 is affirmed. Claimant's attorney is awarded a reasonable attorney fee of $600 for prevailing on the issue of the compensability of the surgery.

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[1] Although at hearing claimant's attorney did not use the term "equitable estoppel," she argues that the employer should be bound by its assurance that the surgery would be covered. (Tr. 8-10). Furthermore, the Referee received evidence concerning the employer's assurances without objection from the employer.

In the Matter of the Compensation of
KATHERINE E. THRASH, Claimant
WCB Case No. 89-15930
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Gale Gage (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Daron's order that upheld the SAIF Corporation's denial of her occupational disease claim for mental stress. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We accept the Referee's "Findings of Fact" with the exception of the second sentence of the fifth full paragraph of page 3 of the Opinion and Order as supplemented below.

Claimant first saw Dr. Sanders, a clinical psychologist, on June 20, 1989. On either June 27 or June 28, 1989, Dr. Sanders conducted his initial intake mental examination and performed psychological testing.

ULTIMATE FINDINGS OF FACT

Claimant suffers from an adjustment disorder. The disorder is generally recognized in the psychological community. The mental disorder required medical services and resulted in disability.

Employment conditions which existed in a real and objective sense included an abusive managerial style from the Chief of Police, the May 12, 1989 incident involving claimant's failure to call an ambulance in a timely fashion, and disciplinary actions resulting from the May 12, 1989 incident.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's mental stress claim was not compensable. We agree.

This claim is for an occupational disease. Claimant's last exposure to potentially causal employment conditions occurred after January 1, 1988. We therefore apply former ORS 656.802 as amended effective January 1, 1988, and before its amendment on July 1, 1990. In order to establish a compensable mental stress condition, claimant must prove by clear and convincing evidence that work related stressors, not otherwise excluded under former ORS 656.802(2), are a material contributing cause of the mental disorder. See Ellen Crawford, 41 Van Natta 1257, 1261 (1989); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Pursuant to former 656.802(1)(b) and (2), to prove a mental disorder, claimant must establish that: (1) she has a mental or emotional disorder which is generally recognized in the medical or psychological community; (2) she required medical services or was disabled; (3) the mental disorder was due to employment conditions which were real and objective; (4) such employment conditions are not generally inherent in every working environment or reasonable disciplinary, corrective or job performance evaluation actions or were associated with the cessation of employment; and (5) the evidence is clear and convincing that the mental disorder arose out of and in the course of employment.

We find that the medical record supports a finding that claimant suffered a psychological condition recognized by the psychological community requiring medical services. Claimant's treating neurologist, Dr. La France, noted on May 15, 1989 claimant's deteriorating emotional condition and recommended she see a psychologist for counseling. He repeated this observation when he saw claimant again on June 14, 1989.

Claimant first sought psychological treatment from Dr. Sanders, a clinical psychologist, on June 20, 1989. On either June 27 or June 28, Dr. Sanders conducted a mental examination and psychological testing. He concluded that claimant suffered symptoms of emotional distress, moderate depression, memory loss, lack of concentration, lowered frustration tolerance, and sleep disturbance. He opined that these symptoms had begun at some time prior to the May 12 incident. He described claimant as an individual under intense emotional pressure with moderate symptoms of anxiety and depression.

Dr. Sanders diagnosed "adjustment disorder with mixed emotional features." This condition is generally recognized in the psychological community. (See DSM III 309.28). Thereafter, until the time of hearing, claimant saw him for weekly psychotherapy sessions for her adjustment disorder. We therefore find that claimant suffered a psychological condition which required medical services.

It was Dr. Sanders' opinion that the major contributing cause of claimant's condition and need for treatment was work related stress. This stress emanated from the negative physical and interpersonal work environment. Relying on claimant's history, he noted the unrealistic demands made by the Chief of Police on employees and the general atmosphere of intimidation and harassment felt by the workers of the Police Department.

Another stressor identified by Dr. Sanders was the May 12, 1989 incident which occurred while claimant was dispatching. On that occasion claimant was required to call an ambulance for a critical patient. She failed to do so in a timely fashion. Dr. Sanders opined that the May incident was the culmination of depression, anxiety and disruptive emotions. He describes the incident as both a symptom and a cause. Specifically, he characterizes it as the "last straw in a very dramatic symptom."

It was Dr. Sanders' view that these negative working conditions resulted in claimant's aforementioned symptoms and adjustment disorder. We find Dr. Sanders' description of the Police Department, including the negative management style of Chief of Police, to be accurate. Further, we find the May incident to have occurred as described as well. Dr. Sanders' testimony was corroborated by claimant's credible testimony, and supported by the testimony provided by the other lay witnesses. Moreover, we note that the record documents a history of difficulty between management and the employees in the Police Department. Accordingly, we find these work conditions existed in a real and objective sense.

We therefore proceed to consider whether or not the working conditions claimant was exposed to were conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions or were associated with the cessation of employment. We have interpreted the phrase "generally inherent in every working situation" to mean conditions that are usually present in all jobs or occupations. Kathleen M. Payne, 42 Van Natta 1900 (1990). Evidence concerning the "generally inherent" issue need not be direct, it may be circumstantial. Louis R. Orman, 43 Van Natta 226 (1991).

Dr. Sanders testified that he was familiar with the working conditions and environment of similar police dispatch operations centers. He testified that

the stressful conditions described by claimant exceeded other centers he had witnessed. Relying upon the testimony of Dr. Sanders, comparing claimant's work environment with other similar work environments, we find that the stressful working conditions to which claimant was exposed to as a Dispatcher were not typical of work places generally.

However, the Referee found that the disciplinary aspects related to the May incident were a significant stressor. For this finding he relied on Dr. Turco's opinion and the absence of an analysis of this factor from Dr. Sanders. Furthermore, the Referee found that the May incident and the resulting discipline could not be disassociated from each other, but rather were simply aspects of the whole situation.

We find that the disciplinary actions claimant was subject to following the May incident played a significant role in claimant's psychological condition. On July 25, 1989, claimant underwent a independent medical examination with Dr. Turco, a psychiatrist. In addition to a mental examination, Dr. Turco reviewed claimant's medical records, including those from Dr. Sanders, and was familiar with her work environment.

He found that claimant's psychological testing, mental status examination and behavior were in normal limits. He also found claimant to be capable of returning to work on a full and regular basis without impairment. Moreover, he concluded that claimant did not have a diagnosable psychological condition requiring medical services. It was, however, his opinion that the major contributing cause of claimant's emotional distress and departure from work was the disciplinary action, especially the expectation that she would lose three days pay, yet still be expected to work those days. Dr. Turco did not consider this discipline to be unreasonable.

On the other hand, Dr. Sanders did not find that the disciplinary actions were causal factors relating to claimant's condition, because claimant had first come to him prior to the disciplinary actions being finalized. However, we do not believe that Dr. Sanders had an accurate history of events by which to make this assessment.

Claimant was first aware that the disciplinary actions were underway as early as June 1. On that date, her immediate supervisor, Sergeant Young, met with claimant and informed her that he was investigating the incident. At this meeting disciplinary action was discussed. On June 13, claimant was presented with a copy of a memo outlining Sergeant Young's recommendations to the Chief of Police with regard to appropriate disciplinary actions. The next day on June 14, claimant was seen by Dr. La France who commented on claimant's psychological condition, noting that she was distraught over a pending disciplinary hearing. By June 16, claimant had been confronted in a formal hearing held by Chief David regarding the specific charges of nonfeasance of office brought against her by the Police Department. It was under these circumstances, that claimant first sought treatment from Dr. Sanders on June 20.

Three days later on June 23 claimant filed a mental stress claim listing as the date of injury the same date that disciplinary actions against her were first initiated on June 1. On June 26, disciplinary action was implemented docking claimant three days pay. This was also the last day that claimant worked. The record indicates that claimant was informed of the disciplinary action on June 28.

Either on June 27 or June 28 claimant again saw Dr. Sanders. On this date, he conducted his initial intake examination and psychological testing. See Tr 29, 217. It was based on this examination and testing that Dr. Sanders made his

diagnosis and drew his conclusions. Thus, we find Dr. Sanders' perception that claimant had come to see him prior to any finalizing of disciplinary actions to be faulty. Rather, the sequence of events indicates that disciplinary actions were well underway prior to the first visit, and more importantly, prior to the more relevant second visit on June 27/28. Neither his report of August 1989 nor his testimony at hearing reflects the fact he was aware of and considered the foregoing.

We also note that claimant credibly and persuasively testified that potential disciplinary actions stemming from the May incident weighed greatly on her mind, and caused her emotional distress. In particular she was upset when she learned the discipline to be imposed consisted of docking her of three days pay.

Based upon Dr. Turco's opinion, the aforementioned sequence of events, and claimant's testimony we conclude that the disciplinary actions played a significant role in claimant's psychological condition and need for treatment. We further note there is no persuasive evidence that this discipline was unreasonable. We note that the record reflects that one of the options available to the Chief of Police for this type of error committed by claimant was immediate dismissal. Here, however, the Police Department chose not to exercise this option, but rather implemented a less severe form of discipline.

To establish compensability there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). There is no doubt that the psychological condition occurred in the course of employment. However, in order to meet the arising out of employment test, the claimant must show a causal link between the occurrence of the condition and a risk connected with her employment. Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983). Previously we have interpreted this language to mean that in order to establish a compensable mental disorder, a claimant must prove by clear and convincing evidence that work related stressors, not otherwise excluded under ORS 656.802(2), are a material contributing cause of the disorder. See Ellen Crawford, Supra, at page 1261.

Although Dr. Sanders opined that the primary stressors were the management style of the Chief of Police, and second, the May incident, we have found that disciplinary actions resulting from the May incident to have played a significant causal role in claimant's adjustment disorder. We realize that Dr. Sanders did not concur with this view. However, as previously noted, we do not rely on Dr. Sanders' opinion on this point because we believe he was not fully aware of the sequence of the events which had transpired prior to his critical examination of claimant on June 27/28. Accordingly, we find there is sufficient doubt as to the validity of Dr. Sanders' opinion with regard to the primary stressors identified by him in causing claimant's condition. Hence, we cannot conclude that it is highly probable that work related stressors, not otherwise excluded by statute, materially caused claimant's mental stress condition. Accordingly, claimant has failed to carry her burden of proof.

ORDER

The Referee's order dated May 11, 1990 is affirmed.

In the Matter of the Compensation of
LINDA D. CROWDER-HICKS, Claimant
WCB Case No. 90-18790
ORDER DENYING MOTION TO REINSTATE REFEREE'S ABATEMENT ORDER
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On March 21, 1991, the insurer requested Board review of the Referee's February 25, 1991 order. The insurer has moved the Board for an order reinstating the Referee's March 27, 1991 order, which abated his February 25, 1991 order. The motion is denied.

FINDINGS OF FACT

On February 25, 1991, the Referee issued his opinion and order, relying upon a recent Board decision. On March 13, 1991, the insurer requested abatement and reconsideration, noting that the Board had abated the decision upon which the Referee had based his order.

On March 19, 1991, the Referee denied the motion for abatement. On March 21, 1991, the insurer mailed, by certified mail, its request for Board review of the Referee's February 25, 1991 order.

On March 27, 1991, the Referee issued an order abating his February 25, 1991 order. On March 28, 1991, the Referee withdrew his March 27, 1991 abatement order, noting that the order was null and void by virtue of the insurer's March 21, 1991 request for Board review.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.298(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Upon the filing of a request for Board review of a Referee's order, jurisdiction over the case vests with the Board. Ramey S. Johnson, 40 Van Natta 370, 371 (1988).

Here, when the Referee issued his March 27, 1991 abatement order, the insurer had already filed its request for Board review. See OAR 438-05-046(1)(b). Consequently, the Referee lacked authority to abate his February 25, 1991 order and the March 27, 1991 abatement order was a nullity. See Ramey S. Johnson, supra.

The insurer concedes that the Referee was without authority to abate his February 25, 1991 order. However, since the Referee is apparently willing to abate his February 25, 1991 order and in the interests of resolving issues at the lowest possible level, the insurer asks the Board to return this matter to the Referee.

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. See James D. Whitney, 37 Van Natta 1463 (1985). Inasmuch as the insurer's request for Board review of the Referee's order preceded the Referee's abatement order, the Whitney policy to resolve issues at the lowest possible level is inapplicable.

Furthermore, our authority to return a case to a Referee is limited to circumstances where the record has been improperly, incompletely or otherwise

insufficiently developed. ORS 656.295(5). Here, such a contention has neither been advanced nor do we make such a finding concerning this record which was presented on stipulated facts.

Based on the foregoing reasoning, the insurer's motion is denied. The parties will be advised of the implementation of a briefing schedule. Upon completion of that schedule, this case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
SEYMOUR HUSSERL, Claimant
WCB Case No. 89-14521
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
James Dodge (Saif), Defense Attorney

Claimant requests reconsideration of our March 13, 1991 order that affirmed a Referee's order which upheld the SAIF Corporation's denials of his claims for his myocardial infarction, angina condition and psychological condition. Specifically, claimant requests reconsideration of the portion of our order which found that, because his termination was a condition causing stress, claimant had not shown by clear and convincing evidence that the disorder arose out of and in the course of employment.

The Court has held that illness resulting from the stress of actual or anticipated unemployment is not compensable. Elwood v. SAIF, 298 Or 429 (1985). However, illness resulting from the circumstances and manner of discharge which can be regarded as events still intrinsic to the employment relationship before termination may be compensable. Elwood, supra.

Claimant argues that the applicable section of the occupational disease law, ORS 656.802(b), is a codification of the Elwood case, insofar as it provides that cessation of employment may not be considered as an employment condition producing a mental disorder. Claimant apparently contends that the stress surrounding his termination resulted from the circumstances and manner of the discharge.

In October 1989, Dr. Turco reported that after the employer gave him the choice between leaving or being terminated, claimant chose to leave. He noted claimant's statement that he felt cheated and wrongfully terminated. In Dr. Turco's opinion, claimant's termination did not appear to have been "fair" and he stated that claimant "had experienced stress associated with this termination, particularly the manner in which it was done...." Dr. Turco also reported that claimant had experienced subsequent stress problems associated with loss of income and concerns about the future.

In January 1990, Dr. Turco reviewed information from the employer and reported that if the employer's statements were accurate, claimant had become upset with what he perceived as unfair treatment, but in reality, the employer's behavior was within the context of IRS and other guidelines. Dr. Turco concluded that claimant, "of course, became distraught at the point of termination."

Based upon Dr. Turco's most recent statement regarding claimant's stress as it related to his termination, we are unable to find that claimant's

psychological condition resulted from the circumstances and manner of his discharge. In any event, our order addressed only claimant's termination, as in determining compensability, we are required to exclude the effect cessation of employment may have had in producing any mental disorder. ORS 656.802(2)(b). Consequently, we conclude that, even if claimant established a mental disorder, he has not shown by clear and convincing evidence that the disorder arose out of and in the course of employment.

Accordingly, our March 13, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 13, 1991 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSE M. REESE, Claimant
Own Motion No. 91-0005M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Parker & Bush, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's February 26, 1991, Own Motion Order on Reconsideration which assessed a penalty-related attorney fee for the SAIF Corporation's unreasonable delay in processing her claim. Claimant contends that SAIF should be assessed a penalty for its delay.

A penalty may not be assessed under ORS 656.262(10)(a) unless there is an unpaid amount of compensation "then due" upon which to base the penalty. Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). Here, citing the Board's opinion in George Violett, 42 Van Natta 2647 (1990), claimant contends that a penalty may be assessed because temporary disability compensation was due and owing at the time of SAIF's delay. We disagree.

In Violett, supra, the carrier unreasonably delayed closure of the claimant's claim beyond the claimant's medically stationary date. The Board concluded that any amounts of compensation awarded by the subsequent Determination Order, the issuance of which was delayed by the carrier's conduct, constitute amounts of compensation "then due" for the assessment of a penalty. However, the claimant in that case had a regular claim in open status and was statutorily entitled to claim closure and evaluation of the extent of his permanent disability. Here, on the other hand, claimant's claim was closed and, because her claim is in own motion status, she was not entitled to reopening of her claim. Indeed, temporary disability compensation was not due and owing claimant until the Board reopened her claim on January 29, 1991. See Stanley R. Libel, 42 Van Natta 2576 (1990). Because no compensation was due at the time of SAIF's unreasonable delay, a penalty cannot be assessed under ORS 656.262(10(a). See Fredrick D. Oxford, 42 Van Natta 476 (1990).

Accordingly, our February 26, 1991, order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 26, 1991, order in its entirety. The parties' rights of reconsideration and appeal run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN W. ROBERTSON, Claimant
and, In the Matter of the Complying Status of
SHUMAN EQUIPMENT COMPANY, Employer
WCB Case Nos. 90-00264 & 90-04391
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

The SAIF Corporation requests review of that portion of Referee Leahy's order that found SAIF conclusively presumed to have insured the alleged noncomplying employer at the time of claimant's injury. We affirm.

FINDINGS OF FACT

In December 1989, claimant filed a low back injury claim with his employer. The employer referred the claim to SAIF, its alleged insurer. On December 21, 1989, SAIF denied the claim, stating that it had not provided coverage for the employer since October 1989.

Claimant requested a hearing, raising the issues of compensability and penalty and attorney fees for an alleged unreasonable denial. The hearing request was assigned WCB Case No. 90-00264, and a hearing was set for May 14, 1990.

On February 15, 1990, a Proposed and Final Order Notice issued, finding the employer to be a noncomplying employer on the date of claimant's injury. The employer requested a hearing and moved that SAIF be joined as a necessary party, asserting that SAIF had provided coverage during the period of the alleged noncompliance. That hearing request was acknowledged as WCB Case No. 90-04391, and a hearing was set for July 13, 1990.

Shortly thereafter, SAIF, pursuant to ORS 656.054, accepted the claim as a processing agent for the alleged noncomplying employer. The employer requested a hearing. It did not dispute the compensability of the claim. Rather, it argued that SAIF should have accepted the claim not as its processing agent, but rather as an insurer pursuant to the coverage it had allegedly provided.

On March 30, 1990, the Hearings Division issued an Order of Joinder, joining SAIF as a necessary party in WCB Case No. 90-04391. The order also noted that the case had been consolidated with WCB Case No. 90-00264 and was set for hearing on May 14, 1990.

At hearing, the parties stated that the sole issue was whether the employer had coverage with SAIF at the time of claimant's injury. The Referee found that SAIF had failed to file, within 20 days of receipt of the Order of Joinder, a written denial of coverage. Therefore, the Referee concluded that SAIF was conclusively presumed to have insured the employer at the time in question under ORS 656.740(2).

SAIF requested review. In response, the employer moved for an order dismissing SAIF's request. It argued that, because the only issue before the Referee was whether it had coverage with SAIF at the time in question, and not whether claimant was entitled to benefits, the Board was without jurisdiction to entertain SAIF's appeal. It believed that, under ORS 656.740(4) and 183.480(2), the proper forum for review of the Referee's order was the Court of Appeals.

By an interim order of October 25, 1990, we denied the motion to dismiss. We found that, contrary to the employer's assertion, the hearing before the Referee was not limited to the Department's noncompliance order. We noted that, because the hearing requests had been consolidated, the hearing also concerned claimant's request to have SAIF's denial of compensation set aside, as well as penalties and attorney fees for an alleged unreasonable denial. Therefore, we concluded that claimant's right to receive compensation, or the amount thereof, was directly at issue and denied the employer's motion to dismiss. Accordingly, the case was returned to the docket to await our review.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF had failed to comply with ORS 656.740(2), which provides:

> "Where any insurance carrier, including the State Accident Insurance Fund, is alleged by an employer to have contracted to provide the employer with workers' compensation coverage for the period in question, the Board shall join such insurance carrier as a necessary party to any hearing relating to such employer's alleged noncompliance and shall serve the carrier, at least 30 days prior to such hearing, with notice thereof. If the carrier does not file with the Board, within 20 days receipt of such notice, a written denial of such coverage, the carrier shall be conclusively presumed to have so insured the employer." (Emphasis supplied).

That statute mandates an insurer, who is charged by an alleged noncomplying employer to have provided coverage for the time in question, to file a written denial of such coverage within 20 days of joinder with the Board. SAIF failed to do so here. Accordingly, under the unambiguous language of the statute, SAIF is conclusively presumed to have so insured the employer during the time of claimant's injury.

SAIF contends that ORS 656.740(2) does not apply here, because the joinder was unnecessary. It argues that it already was a party to the proceeding by virtue of having denied claimant's injury claim on December 21, 1989.

We agree that SAIF did issue a denial of claimant's claim on the ground that it did not provide insurance for his employer at the time of injury, and that claimant did request a hearing therefrom. However, claimant's claim was an entirely separate proceeding from that brought by the employer contesting the Department's noncompliance order. The two proceedings were assigned different case numbers and originally were scheduled for separate hearings. Accordingly, when SAIF was alleged to have contracted to provide the employer with insurance for the period in question, joinder was necessary and SAIF was required to comply with the requirements of ORS 656.740(2).

SAIF also argues that it provided written notice, as required by ORS 656.740(2), when it filed an exhibit list with the Board on March 23, 1990, which contained the December 21, 1989 denial. It maintains that, prior to the March 30, 1990 joinder order, the Board was notified of SAIF's intent to disclaim liability on the basis of lack of coverage. Again, however, the exhibit list was filed with the Board in WCB Case No. 90-00264, which concerned claimant's request for hearing of SAIF's denial. The exhibit list was not filed with regard to the proceeding brought by the employer contesting the Department's noncompliance order, which eventually resulted in the March 30, 1990 joinder order.

ORDER

The Referee's order dated June 6, 1990 is affirmed.

In the Matter of the Compensation of
MARK N. WIEDLE, Claimant
WCB Case No. 90-10656
ORDER ON REVIEW
George W. Sohl, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers, Cushing and Westerband.

The insurer requests review of that portion of Referee Myzak's order that set aside its denial of claimant's left hand injury claim. On review, the issue is compensability.

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

We agree with the insurer that, because the hearing was convened after July 1, 1990, it is subject to the 1990 amendments to the Oregon Workers' Compensation Law. See Oregon Laws 1990, Chapter 2, section 54, paragraphs (1) & (2). However, we do not agree that, under amended ORS 656.005(7)(a), claimant must prove that his employment was the "major" contributing cause of his disability.

ORS 656.005(7)(a) defines a compensable injury as "an accidental injury * * * arising out of and in the course of employment." Under Oregon case law, prior to enactment of the 1990 amendment, an injured worker was required to prove that his work was a material contributing cause of his disability to establish compensability. Summit v. Weyerhaeuser Co., 25 Or App 851 (1976). However, the 1990 legislature amended ORS 656.005(7)(a) to require a major contributing cause standard of compensability for certain conditions. The amendment provides:

> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.
>
> "(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." Oregon Laws 1990, section 3. (Emphasis supplied.)

We find no ambiguities in the statute as applied to this situation. Therefore, we construe it according to its plain meaning. Perez v. State Farm Mutual Ins. Co., 289 Or 295 (1980).

The 1990 amendment clearly contemplates a major contributing cause standard of compensability for consequences of compensable injuries or worsenings of preexisting conditions. Although the amendment limits an employer's liability

for complications that arise from an industrial injury, it does not affect the standard of compensability for the initial industrial injury. The language defining a compensable injury remains the same; only the proof required for consequential conditions and worsenings of preexisting conditions has been amended to a major contributing standard. [1]

In this case, claimant injured his hand in an altercation with his supervisor. Because there is nothing to suggest that his claim for compensation involves a consequential condition or a worsening of a preexisting condition, claimant need only prove that his work was a material contributing cause of his disability.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $700 is a reasonable assessed fee for claimant's counsel's efforts on review concerning the issue of compensability. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue presented, and the value of the interest involved.

ORDER

The Referee's order dated September 7, 1990 is affirmed. For services on Board review, claimant's attorney is awarded $700, payable by the insurer.

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[1] Although resorting to legislative history is unnecessary as the statute is sufficiently clear on its face as applied here, the legislative history of the 1990 amendments lends no support to the insurer's position. As stated by Jerry Keene, who testified before the Special Committee on behalf of the Association of Workers' Compensation Defense Attorneys:

> "[The amendment] does not change the standard of causation for the initial industrial injury. That language is arising out of and in the course of employment, which the courts translate as material contributing cause. * * * That is not changed in the basic industrial injury definition." Minutes, Interim Special Committee on Workers' Compensation, May 3, 1989, Tape 8, Side B at 008.

In the Matter of the Compensation of
JEFFREY D. DENNIS, Claimant
WCB Case Nos. 90-06053, 89-25879 & 90-05826
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Aetna Casualty Company (Aetna) requests review of those portions of Referee Thye's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) assessed a penalty for an unreasonable delay in accepting or denying that claim; and (3) upheld the responsibility denial of the SAIF Corporation, as insurer for Helligso Construction, for claimant's "new injury" or occupational disease claim for the same condition. Claimant cross-requests review of those portions of the Referee's order that: (1) assigned responsibility for claimant's current condition to Aetna; (2) declined to assess a penalty for Aetna's allegedly unreasonable delay in payment of interim compensation for the period from September 6, 1989 through September 26, 1989; and (3) did not order interim compensation paid for the period from January 10, 1990 through January 12, 1990. On review, the issues are compensability, responsibility, interim compensation and penalties and attorney fees.

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

As a preliminary matter, we note that, although the Referee assessed a penalty and related attorney fee for Aetna's unreasonable refusal to pay interim compensation for the period from January 10, 1990 through January 12, 1990, he did not order the compensation paid. Claimant requests that we order interim compensation paid for those three days. Inasmuch as there is no argument to the contrary, we grant claimant's request.

Penalties for Aetna's untimely payment of interim compensation and for unreasonable delay in acceptance or denial

Aetna paid interim compensation for the period from September 6, 1989 through September 26, 1989 (the September compensation) on January 3, 1990. (See Ex. 5A4). Claimant raised the issue of unreasonable delay in the payment of the September compensation in his request for hearing, but the Referee did not address it. Rather, he assessed a penalty of 25 percent of the September compensation for Aetna's unreasonable delay in acceptance or denial of claimant's aggravation claim.

Aetna requested review of the Referee's penalty assessment for its unreasonable delay in accepting or denying the claim, contending that, inasmuch as it paid the September 1989 interim compensation before the January 12, 1990 denial, there were no "amounts then due" upon which to base a penalty.

When the initial 60 days following notice of the claim had run, the insurer was required to accept or deny the aggravation claim, or risk imposition of penalties and attorney fees. ORS 656.262(8) & (10). Because the denial did not issue until January 12, 1990, long after the November 26, 1989 deadline, and the lateness is unexplained, we conclude that the insurer's nonaction constituted an unreasonable delay in acceptance or denial of the claim.

Aetna cites Wacker Siltronic v. Satcher, 91 Or App 654 (1988), for the proposition that only amounts due on the date of the denial are "amounts then due" for the purpose of penalty assessment. We do not read Satcher to have this restrictive effect.

In Satcher, the court addressed the question of whether penalties may be assessed not only on amounts due at the time of the denial, but also on amounts due at the time of the hearing. As between these two penalty bases, the court held that, in the case of a late denial, only the amounts due at the time of the denial support a penalty. Moreover, the court stated: "If employer issued a late denial, but had paid interim compensation until then, there would be no 'amounts then due' on which to base a penalty." Satcher, supra at 658, emphasis added. Here, although some compensation was paid, some was not. By our reading, Satcher suggests that some compensation remained "then due" in the case before us.

Aetna's reading of Satcher is also unpersuasive because it would allow an insurer to effectively cure an unreasonable delay by simply "paying up" the day before the denial. Inasmuch as ORS 656.262 expressly provides for a penalty for unreasonable delay, we are unwilling to conclude that it also provides for a cure after such a delay.

Finally, we have previously determined that the delay period is the "then" with regard to the term "amounts then due." George Violett, 42 Van Natta 2647 (1990). To arrive at any other result would render the penalty provision utterly toothless. Harold A. Lester, 37 Van Natta 745, 747 (1985).

For the above reasons, we conclude that the penalty basis for an untimely denial includes that compensation which was due but unpaid during the delay period, i.e., between the date when the denial became untimely (the 61st day after notice of the claim) and the denial date. In the case before us, the September compensation was due during the delay period, and thus, it is an amount "then due" for penalty purposes. Therefore, we conclude that the Referee properly assessed a penalty on this basis.

On review, claimant also contends that he is entitled to a penalty for Aetna's late payment of the September compensation. As we have noted, the Referee did not address this issue.

It is undisputed that the September compensation was not paid until January 3, 1990. Inasmuch as the September compensation was due 14 days after Aetna received notice of claimant's inability to work due to his worsened condition, its payment was late. See former ORS 656.262(4); former ORS 656.273(6); former OAR 436-60-150(3). Inasmuch as the lateness is unexplained, we conclude that it was unreasonable. However, no additional penalty is allowed because the maximum 25 percent penalty has already been assessed on the only compensation due. See Kim L. Haragan, 42 Van Natta 311, 313 (1990); Rob Cohen, 39 Van Natta 649, 652 (1987).

However, claimant's attorney is entitled to a reasonable assessed attorney fee, whether or not there are "amounts then due" so long as there is "unreasonable resistance to the payment of compensation under ORS 656.382. Lloyd L. Cripe, 41 Van Natta 1774 (1991). In this case, we conclude that both the failure to pay the September compensation and the untimely denial were instances of such unreasonable resistance. However, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that the Referee's assessed fee of $500 adequately compensated claimant's counsel for his efforts on both issues. Therefore, no additional fee will be assessed.

Claimant's attorney is also entitled to a reasonable assessed fee for his services on review, payable by Aetna. ORS 656.382(2); Cigna Insurance Co. v. Crawford, 104 Or App 329 (1990). Having considered the abovementioned factors, we find that a reasonable fee for claimant's counsel's services on review concerning the issue of compensability of the aggravation claim raised by Aetna is

$300. In reaching this conclusion, we have particularly considered the time devoted to the case on review and the value of the benefit secured for claimant.

ORDER

The Referee's order dated June 1, 1990 is affirmed in part and modified in part.

In the Matter of the Compensation of
TODD E. EARNEST, Claimant
WCB Case No. C1-00346
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

On February 14, 1991, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $20,000 by SAIF Corporation, claimant agreed to fully release his right to future workers' compensation benefits, except medical services, for his compensable injury. However, by order dated February 26, 1991, the Board set aside the proposed agreement on the grounds that the agreement failed to provide at the conclusion of the agreement, a prominent or bold face order paragraph in accordance with OAR 438-09-020(1)(c).

On March 8, 1991, the Board amended OAR 438-09-020 (WCB Admin. Order 1-1991) to allow parties to submit required information that had been omitted from the initial agreement, provided no order has issued setting aside the agreement. See OAR 438-09-020(2)(a). Second, the Board promulgated OAR 438-09-035 (WCB Admin. Order 1-1991) to allow for motions for reconsideration of orders, provided the motion is filed within 10 days of the date of mailing of the order.

Here, however, the Board received the proposed Addendum on March 6, 1991, prior to the enactment of the new rules. As such, we find the aforementioned recent changes to the rules are not applicable to the motion before us now. Therefore, we construe the parties' letter of March 5, 1991 as a motion for reconsideration.

On reconsideration we note that the parties executed the agreement in December 1990, but for unstated reasons did not file the agreement with the Board until February 14, 1991. Therefore, we find that the agreement was entered into prior to the adoption of the current version of OAR 438-09-020(1)(c). Thus, when the parties executed the agreement there was no requirement to include the now required order clause. Under these circumstances, the parties' request for reconsideration of the Board's order is granted.

The Board finds that the terms of the agreement are in accordance with all statutory and administrative prerequisites. On reconsideration, as modified herein, the parties' claim disposition agreement is approved, hereby fully and finally resolving this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
PHILIP S. HOLDREN, Claimant
WCB Case No. 90-01593
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee McWilliams' order that increased his unscheduled permanent disability award for a low back injury from 33 percent (105.6 degrees), as awarded by Determination Order, to 35 percent (112 degrees). On review, the issue is extent of unscheduled disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was entitled to 35 percent unscheduled permanent disability under the standards. We apply the "standards" in effect on October 2, 1989, the date of the Determination Order.

The appropriate value for claimant's age of 40 years is 1. Former OAR 436-35-290(4).

The appropriate value for claimant's high school education is 0. Former OAR 436-35-300(a).

Claimant's highest SVP during the ten years prior to the date of hearing was 7 as a mechanic (DOT 625.281-014). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

The Referee concluded that claimant did not have competence in a specific vocational pursuit. On review, the insurer argues that, because claimant has owned and operated his own business for over two years, he has demonstrated competence in a specific vocational pursuit. We agree. Competence in a "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off-the-job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

In the present case, we agree that claimant's position as lead-man in the employer's repair shop, in addition to his two years of experience as a business owner, demonstrate that he has acquired sufficient experience and training to perform other than an entry-level position. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Before his injury claimant performed work in the medium category. The parties agree that, following his injury, claimant returned to work in the sedentary to light category. We conclude that, because claimant previously worked in the medium category and returned to modified work requiring a sedentary to light physical capacity, the Referee properly assigned an adaptability value of 2.5. Former OAR 436-35-310(3).

The Referee found that claimant was entitled to a total impairment rating of 27. In regard to the value assigned to impairment, claimant disagrees only with that portion of the Referee's order that declined to award a value of 5

percent for his chronic low back condition limiting repetitive use of an unscheduled body part. See former OAR 436-35-320(4).

Claimant testified that he is unable to bend at the waist to pick up objects. We are unable to find evidence, however, that claimant has limitations on repetitive bending as opposed to the limits considered in the range of low back motion values. We, therefore, agree with the Referee that claimant has not established entitlement to a value for a chronic condition limiting repetitive use.

The insurer argues that the Referee should not have relied on the range of motion findings in the May 1989 exam, as there was no orthopedic or neurological basis for claimant's restricted motion. The insurer also asserts that the Referee incorrectly assigned a value of 4 percent to derangements at L2-3 and L3-4, as "partial desiccation of the discs" is not equivalent to a lesion of the disc or an unoperated bulge. We disagree with the insurer's contentions in regard to the impairment and we conclude that the Referee properly assigned values for range of motion and for claimant's disc derangements.

For reduced thoracolumbar flexion (from 90 degrees to 10 degrees), claimant is entitled to an impairment value of 8 percent. Former OAR 436-35-360(6). For reduced thoracolumbar extension (from 30 degrees to 0), claimant is entitled to an impairment value of 3 percent. Former OAR 436-35-360(7). For loss of right and left flexion (from 30 degrees to 13 degrees), claimant is entitled to an impairment value of 3.4 percent for each side. Former OAR 436-35-360(8). For loss of right and left rotation (from 30 degrees to 20 degrees), claimant is entitled to an impairment value of 2 percent for each side. Former OAR 436-35-360(9). For a total rating of the thoracolumbar area, the values for loss of motion are added. Former OAR 436-35-360(10). They total 21.8 percent.

In addition to reduced spinal motion, for his unoperated disc bulge at L5-S1, claimant is entitled to an impairment value of 4 percent. Former OAR 436-35-350(2). For disc derangements at the L2-3 and L3-4 levels, claimant is entitled to a value of 4 percent each. Former OAR 436-35-350(2). Claimant's general spinal findings are combined for a total of 11.5 percent. Roger F. Slade, 43 Van Natta 631 (1991).

The impairment values for claimant's lost range of motion (21.8) and general spinal findings (11.5) are combined to obtain a single impairment value for the spine. Former OAR 436-35-360(11). Here, 21.8 percent and 11.5 percent combine to a value of 30.8 percent.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (1), is added to his education value (1), the sum is 2. When that value is multiplied by claimant's adaptability value (2.5), the product is 5. When that value is added to claimant's impairment value (30.8), the result is 35.8 percent unscheduled permanent partial disability. That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 36 percent.

ORDER

The Referee's order dated June 15, 1990 is modified. In addition to the Referee's increased award of unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, for a total award of 36 percent (115.2 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's counsel by the insurer. However, the total attorney fee awarded by the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
ANNA L. HUSTON, Claimant
WCB Case No. 88-21647
ORDER ON REVIEW
Hollander, et al., Claimant Attorneys
Rudolph B. Harris (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Bennett's order which declined to grant permanent total disability. The SAIF Corporation cross-requests review of that portion of the Referee's order which allowed the admission of Exhibit 48 after the record was initially closed. On review, the issues are admission of evidence and permanent total disability.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

OAR 438-07-025(1) allows a Referee discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(2) provides that a party moving for reconsideration must provide an explanation why such new evidence could not have reasonably been discovered and produced at the hearing.

On October 13, 1989, after closing arguments had been received, claimant requested that the record be reopened for submission of Exhibit 48, "Director's Review and Order" issued on October 9, 1989, regarding claimant's eligibility for vocational assistance. A review by the Director had been requested by claimant on May 12, 1989. (Ex. 48). In her request to reopen the record, claimant explained that the Director's Review and Order had been issued just four days earlier and that she could not have acquired the evidence sooner. SAIF did not request an opportunity to rebut Exhibit 48.

We conclude that Exhibit 48 is material evidence and that claimant adequately demonstrated that she could not have reasonably discovered and produced the Director's Review and Order at the hearing. Accordingly, we conclude that the Referee properly acted within his discretion to reopen the record for submission of Exhibit 48.

Permanent Total Disability

We adopt the Referee's "Opinion" with respect to the issue of whether claimant is permanently totally disabled. Claimant has not carried her burden to prove that she is permanently totally disabled.

ORDER

The Referee's order dated November 2, 1989 is affirmed.

In the Matter of the Compensation of
LYLE A. McMANUS, Claimant
WCB Case No. 90-09537
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Darrell E. Bewley, Defense Attorney

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee McWilliams' order that set aside its denial of claimant's low back injury claim. Contending that the Referee erred in declining to admit into evidence Exhibit 14 which was offered for the purpose of impeaching claimant's credibility, the insurer seeks reversal of the Referee's order and a new hearing.

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

Referees are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7); William G. Mattison, 41 Van Natta 2331 (1989). Referees have broad discretion when rendering procedural and evidentiary rulings. Jackson P. Shull, 42 Van Natta 1206 (1990).

Here, the insurer contends that the Referee erred in excluding Exhibit 14, which was a typed statement prepared by the employer's bookkeeper that had been placed in the employer's personnel file. The unsworn statement, which was prepared some six months before the hearing, was signed by a Mr. Jensen. The statement declared that claimant had told Mr. Jensen that claimant had injured his back "off the job." Mr. Jensen was neither subpoenaed as a witness nor appeared personally to testify at the hearing.

Reasoning that the statement was not a document kept in the course of regularly conducted business activities for the employer and that the signator of that unsworn statement was unavailable for cross-examination, the Referee found that in the interests of substantial justice the exhibit should be excluded from the record. (Tr. 143 - 147). Considering the circumstances described above, we conclude that the Referee did not abuse her discretion in excluding the exhibit. In any event, even if the excluded exhibit had been admitted into evidence, we would accord it little weight since the declarant was unavailable for cross-examination.

ORDER

The Referee's order dated November 26, 1990 is affirmed. For services on review, claimant's attorney is awarded $600, to be paid by the insurer.

In the Matter of the Compensation of
DONALD M. HUGHES, Claimant
Own Motion No. 90-0584M
OWN MOTION ORDER ON RECONSIDERATION
Douglas Hess, Claimant Attorney

By Own Motion Order April 4, 1991, the Board reopened claimant's claim for the payment of temporary disability benefits. By letter dated April 3, 1991, claimant requests the assessment of penalties and related attorney fees for the carrier's allegedly unreasonable delay in processing his claim for medical

services and his claim for temporary disability benefits. Because the Board did not receive claimant's letter until April 5, 1991, the day after issuance of the Own Motion Order, the letter is viewed as a request for reconsideration of the April 4, 1991, order. Additionally, claimant seeks Board authorization of an approved fee for his attorney's efforts which culminated in the Board's reopening of his claim.

We begin with claimant's request for penalties and related attorney fees. Claimant has a lifetime right to medical services for his compensable injury. See ORS 656.245. Therefore, we lack own motion jurisdiction of his claims for medical services. See Margarette I. Schaffer-Wright, 39 Van Natta 1113, 1115 (1987). Inasmuch as we lack jurisdiction to review his medical services claims, we likewise lack own motion jurisdiction to review claimant's request for penalties and attorney fees relating to the processing of those claims. Those issues should instead be directed to the Hearings Division. See ORS 656.319(1).

On the other hand, because claimant's aggravation rights have expired, we have own motion jurisdiction of his claim for temporary disability benefits. See ORS 656.278(1)(a); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Robin S. Masse, 42 Van Natta 1832 (1990); Derek Oliver, 42 Van Natta 1792 (1990). Therefore, the assessment of a penalty and attorney fee for the carrier's allegedly unreasonable processing of his claim for temporary disability benefits is within our own motion jurisdiction.

The record shows that the carrier first received claimant's claim for reopening on October 12, 1990. At that time, the carrier was required to submit to the Board its recommendation concerning that claim within 90 days after receipt of the claim. See OAR 438-12-025(2). However, the carrier did not submit its own motion recommendation to the Board until March 28, 1991, more than two months late, and has not offered a reasonable explanation for that delay. Therefore, we find the carrier unreasonably delayed the payment of compensation.

Nevertheless, a penalty may not be assessed unless there are amounts of compensation "then due" upon which to base the penalty. See ORS 656.262(10)(a); Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988); Frederick D. Oxford, 42 Van Natta 476 (1990). Because claimant's claim is in own motion status, he was not entitled to the payment of temporary disability benefits until we reopened his claim for benefits on April 4, 1991. See Rose M. Reese, 43 Van Natta 852 (1991); Stanley R. Libel, 42 Van Natta 2576 (1990). Because no benefits were due and owing at the time of the carrier's unreasonable delay, a penalty may not be assessed under ORS 656.262(10(a). See Rose M. Reese, supra.

On the other hand, even in the absence of any amounts of compensation "then due," a penalty-related attorney fee may be assessed under ORS 656.382(1) if the carrier unreasonable resists the payment of compensation. See Ellis v. McCall Insulation, 308 Or 74, 78 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). The carrier's delay in submitting its recommendation ultimately delayed the issuance of the Board's order reopening claimant's claim. That amounts to an unreasonable resistance to the payment of compensation. Accordingly, we assess a penalty-related attorney fee of $200 pursuant to ORS 656.382(1).

Finally, we agree that claimant's attorney should be allowed an approved fee for his efforts in obtaining increased disability compensation for claimant. After reviewing the attorney retainer agreement and the factors set forth in OAR 438-15-010(4), we approve a reasonable attorney fee equal to 25 percent of the additional compensation awarded by the Board's April 4, 1991, order, not to exceed $300.

Our April 4, 1991, order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 4, 1991, order in its entirety. The parties' rights of reconsideration and appeal run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD B. KARSTETTER, Claimant
Own Motion No. 66-0229M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for medical benefits relating to his July 26, 1928, industrial injury. Claimant's aggravation rights have expired. SAIF recommends that claimant's claim be reopened to provide medication. However, SAIF does not recommend payment of travel expenses totalling $2.64 for travel to and from the pharmacy to obtain medication.

For conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b). Here, we find that the medication is reasonable and necessary and required to maintain claimant's medically stationary status for the compensable injury. We conclude, therefore, that claimant's claim should be reopened to provide those medical services. See OAR 438-12-037(1)(c). Accordingly, claimant's claim is reopened for the provision of medication in an amount not to exceed $102.63.

The above authorization does not include reimbursement to claimant for travel expenses to and from a local pharmacy to obtain medication for his injury. The Board may authorize reimbursement for travel expenses incurred in the treatment of the compensable injury. Generally, the Board authorizes reimbursement for travel expenses incurred in treating with medical providers such as doctors, clinics and therapists. Here, however, claimant seeks reimbursement for travel expenses to and from a pharmacy located in the same town in which claimant resides. We decline to authorize reimbursement for such expenses. Accordingly, we deny authorization of reimbursement for travel expenses in the amount of $2.64. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. By this order, the claim is again closed.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN P. ROCHE, Claimant
WCB Case Nos. 89-22635 & 89-20801
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee McCullough's order that: (1) upheld CNA Insurance Companies' denial of the compensability of claimant's "new injury" claim for a left shoulder and neck condition, and responsibility for claimant's "new injury" claim for a left elbow condition subsequent to May 15, 1989, (2) upheld Liberty Northwest Insurance Company's (Liberty) denial of compensability of an aggravation claim for claimant's left shoulder and neck; (3) affirmed a Determination Order, issued on October 4, 1989 awarding no scheduled permanent partial disability for the left elbow; and (4) upheld Liberty's denial of claimant's acupuncture treatment in September and

October 1989. The issues on review are compensability, responsibility, premature closure, extent of scheduled permanent partial disability, and medical services.

The Board affirms and adopts the order of the Referee with the following comment. The Referee, in his conclusions on responsibility for the elbow condition, states that once the question of compensability has been decided adverse to the second employer, the second employer/insurer has the burden of proving that the second injury did not independently contribute to claimant's worsened disability, citing Linda L. Wise, 42 Van Natta 115 (1990). Since the Referee issued his order, the Court of Appeals has addressed this issue in Stevens Equipment Company v. American Fabricators, 106 Or App 354 (1991), and Delta/McLean Trucking v. Wyncoop, 106 Or App 319 (1991). There the court held that the last employer against whom the claimants had an accepted claim is presumptively responsible, and has the burden of establishing that the claimants' subsequent employment independently contributed to their condition. In this case it really makes no difference who has the burden because there is no evidence that the work exposure at CNA's insured independently contributed to any pathological worsening of claimant's left elbow condition.

ORDER

The Referee's order dated August 2, 1990 is affirmed.

April 9, 1991 Cite as 43 Van Natta 866 (1991)

In the Matter of the Compensation of
ALICE M.SKETO, Claimant
WCB Case Nos. 88-04550 & 88-14919
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys
Rod Peters (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

The noncomplying employer requests review of that portion of Referee Fink's order that set aside its denial of claimant's carpal tunnel syndrome. Claimant cross-requests review of those portions of the order that: (1) awarded an assessed fee for prevailing on the denial in an amount less than that sought in counsel's statement of services; and (2) affirmed a Determination Order that awarded no unscheduled permanent partial disability for claimant's neck, shoulder and back condition. On review, the issues are timeliness of the employer's hearing request, compensability, extent of permanent partial disability, and attorney fees.

This case is before us after the record was supplemented with additional evidence in accordance with our September 13, 1990 Interim Order (Remanding). The additional evidence takes the form of a document entitled "Stipulated Facts" which is executed by counsel for claimant, for the noncomplying employer and for the SAIF Corporation.

Since issuance of our Interim Order, the Court of Appeals has issued its decision in Blain v. Owen, 106 Or App 285 (1991). We now issue our order in view of both the new evidence and the clarification of the law. We reverse in part and affirm in part.

FINDINGS OF FACT

Procedural History

On November 4, 1986, claimant filed a claim for injury to her back and left shoulder as a result of an injury while working for the noncomplying employer. The Compliance Section investigated; issued a Notice of Proposed and Final Order declaring the employer noncomplying on January 5, 1987; and referred the claim for processing by SAIF. On February 13, 1987, SAIF accepted a low back strain.

Meantime, in January 1987, claimant filed a separate claim for carpal tunnel syndrome. The Compliance Section investigated; and investigator Jon Sallquist made a report. A copy of the report was sent to the employer's attorney. An amended proposed and final order issued on April 8, 1987, again declaring the employer noncomplying. Whereas the first Notice had stated that claimant was a subject worker of the employer on October 17, 1986, the second Notice stated that claimant was a subject worker of the employer on October 17, 1986 and in October 1986 generally. On the same day, a claim filed by claimant was referred to SAIF for processing. It is impossible to determine from the face of the referral letter what was forwarded. A copy of the referral letter was sent to the employer's attorney.

By letter dated June 10, 1987, SAIF advised claimant's attorney that the Workers' Compensation Department had referred a claim for carpal tunnel syndrome for processing, that SAIF would not set up a new claim file, and that the carpal tunnel syndrome would be "incorporated" in the existing claim. No separate acceptance form issued in the new claim. A copy of the letter was not mailed to the noncomplying employer.

Meantime, the noncomplying employer had requested a hearing challenging the Notice of Proposed and Final Order-Amended and seeking to litigate "whether the employer was responsible for the injury and/or whether the claim of Alice M. Sketo is compensable." The hearing was convened on February 17, 1988. At that time, the noncomplying employer learned that SAIF had accepted the claim for carpal tunnel syndrome. The noncomplying employer withdrew its request for hearing but indicated a desire to challenge the acceptance of the carpal tunnel syndrome. The following day, the noncomplying employer requested a hearing on the compensability of the carpal tunnel syndrome.

The parties were notified that the noncomplying employer's request for hearing would be consolidated with a pending hearing request, WCB 88-03660.

At the time set for hearing, a year later, following issuance of the Court of Appeals' decision in Derryberry v. Dokey, 91 Or App 533 (1988), the noncomplying employer issued a formal denial of the carpal tunnel condition. Claimant immediately requested a hearing.

Other Basic Facts

Claimant sustained injury to her low back, upper back, neck, and shoulder as a result of an October 17, 1986 lifting incident while working for the noncomplying employer.

The injury caused cervical and lumbar strains. Claimant experienced radiating pain into both legs. She treated conservatively with Dr. Campbell, D.O. She transferred her care to Dr. Spina, M.D. Her condition improved with time, and she was released to work on May 18, 1987. Claimant quit work in July in order to care for her children. She has not been examined by Dr. Spina since February 1988.

Claimant experiences occasional flareups of pain. The pain is not disabling.

The claim was closed by Determination Order on August 4, 1988. The Determination Order found claimant medically stationary on June 23, 1988. Claimant was awarded temporary disability only. She requested a hearing on the Determination Order.

During claimant's treatment for her compensable back injury, claimant reported upper extremity symptoms which had come on prior to the injury. Dr. Spina reported that the symptoms were compatible with carpal tunnel syndrome; he referred claimant to Dr. Wilson, neurologist, and later to Dr. Mason, neurosurgeon, for further workup. Dr. Mason directed studies of the cervical spine and of nerve conduction. Both studies were within normal limits and did not explain claimant's symptoms. Nerve conduction studies were repeated by Dr. Wilson, M.D. in August 1988. Again, the studies were essentially normal. No surgery was performed.

CONCLUSIONS OF LAW AND OPINION

Compensability of the Carpal Tunnel Syndrome

The Referee set aside the noncomplying employer's denial of the carpal tunnel syndrome based on his reading of Derryberry v. Dokey, 91 Or App 533 (1988) and Bauman v. SAIF, 295 Or 788 (1983). Although he observed that on the merits the condition was not compensable, he granted the noncomplying employer no relief on its request for hearing on the compensability issue.

In our Interim Order (Remanding), we observed that the noncomplying employer had no authority to issue a denial and that the noncomplying employer may raise the compensability issue only by requesting a hearing. Clark v. Linn, 98 Or App 393 (1989). To that degree we were correct. Therefore, we will affirm that portion of the Referee's order that set aside the denial.

However, in our Interim Order, we also stated that the noncomplying employer's right to challenge the compensability of the claim for carpal tunnel syndrome depended on whether or not the noncomplying employer requested a hearing on compensability within 60 days of the referral of the claim to SAIF by the Compliance Section, Workers' Compensation Division, Department of Insurance and Finance. We remanded for supplementation of the record with facts relevant to that understanding of the law. The parties have obliged. However, the court's decision in Blain v. Owen, supra, suggests that our analysis was wrong.

The court held in Blain that a noncomplying employer may challenge the compensability of a claim at any time. ORS 656.283. That being the case, the noncomplying employer here is entitled to a hearing on compensability unless the noncomplying employer waived that right by failing to raise it during an earlier proceeding. The record establishes that the noncomplying employer did not become aware of the acceptance of the carpal tunnel syndrome until the day of the February 17, 1988 hearing. The order dismissing the request for hearing specifically reserved the compensability issue. Consequently, we hold that the employer has not waived its right to challenge the compensability of the claim and may do so in this proceeding.

On the merits, we conclude that the carpal tunnel condition is not compensable. Although the onset of symptoms occurred while claimant was working for the noncomplying employer, there is no medical evidence in the record which suggests that the condition is compensable on either a disease or an injury theory: The evidence suggests that neither claimant's work activities nor the

compensable back injury was a material contributing cause of the carpal tunnel condition. Dr. Spina, who initially diagnosed possible carpal tunnel syndrome opined on July 6, 1987, that the carpal tunnel syndrome, was unrelated to work. A year later he simply stated that he could not explain the etiology of the condition. Dr. Wilson opined that the condition was unrelated to the back injury. The Orthopaedic Consultants, after examination of claimant in June 1988, took the same position. Dr. Mason, who treated claimant on referral, also was unable to relate any of the symptomatology to the injury. There is no contrary medical opinion. Therefore, the condition is not compensable on either an injury or a disease theory.

Permanent Partial Disability

The Determination Order awarded no permanent disability for the compensable back condition. The Referee found that claimant had no permanent impairment due to the injury and affirmed the Determination Order. He noted that claimant had no loss of range of motion, no atrophy, and no other objective indicia of impairment.

On review, claimant contends only that she is entitled to an award of permanent partial disability, scheduled or unscheduled, for chronic conditions interfering with repetitive use. She relies on her own testimony about her inability to lift, carry and use her arms repetitively.

Claimant's compensable condition was medically stationary after January 1, 1988 and her claim was closed after July 1, 1988. We conclude that claimant's disability must be rated in accordance with the standards for rating of permanent disability adopted by the Director of the Department of Insurance and Finance pursuant to former ORS 656.726(3)(f). ORS 656.295(5).

We apply the "standards" effective at the time of the Determination Order in rating disability. OAR 438-10-010. Because the claim was closed on August 4, 1988, we apply the "standards" effective as of July 1, 1988 (WCD Admin. Order 3-1988). See former OAR 436-35-001 et seq.

WCD Admin. Order 3-1988 did not provide for assignment of any impairment value for chronic conditions limiting the use of a body part. This concept was first introduced in WCD Admin. Order 6-1988, effective January 1, 1989. The applicable version of the standards, however, did permit an award for disabling pain. Former OAR 436-35-010(2)(a) and OAR 436-35-320(1)(a).

Nevertheless, like the Referee, we are not persuaded that claimant's pain is disabling. Dr. Spina, who last examined claimant in February 1988, stated that claimant had essentially completely recovered from the low back strain although she had continuing symptoms in the neck. He described her disability of the low back as "minimal." Of this minimal disability, he indicated that some was caused by claimant's excessive weight rather than by the compensable injury. The Orthopaedic Consultants, who examined claimant more recently, in June 1988, took a history of approximately weekly neck symptoms lasting for a few minutes, essentially no low back symptoms, and occasional hip symptoms lasting only a few hours. They opined that claimant had no impairment due to the injury. We give greater weight to this more recent report than to that of Dr. Spina.

Claimant's testimony at hearing was essentially consistent with her comments to the Orthopaedic Consultants. She suffers occasional low back and hip symptoms and therefore avoids doing certain household chores. We are not persuaded, in view of the medical evidence, that the symptoms, although unpleasant, are disabling. Therefore, claimant is entitled to no compensation for permanent disability.

Attorney Fees

The Referee awarded claimant's attorney an assessed fee of $300 for prevailing on the noncomplying employer's denial of the carpal tunnel syndrome. On review, claimant contends that the fee was insufficient. The noncomplying employer does not challenge the assessment of a fee but contends that the fee was adequate. We agree.

After hearing, claimant submitted a statement of services approximating the time expended in this matter as 7.5 hours. Claimant litigated a multiplicity of issues at hearing including permanent disability and premature claim closure as well as the denial and compensability issues. Although the denial was properly set aside because the noncomplying employer has no authority to issue a denial, claimant reaps little benefit from her attorney's success in view of her lack of need for ongoing medical services for the condition and in view of our finding that the condition is not in fact compensable. For all of these reasons, the amount of the fee was consistent with OAR 438-15-010(6).

ORDER

The Referee's order dated June 9, 1989 is affirmed in part and reversed in part. That portion of the order that denied relief pursuant to the request for hearing on the compensability issue is reversed. The carpal tunnel syndrome is declared not compensable. The balance of the order is affirmed.

In the Matter of the Compensation of
DONALD R. BEYERLIN, Claimant
Own Motion No. 89-0146M
OWN MOTION ORDER
Wurtz, Logan & Logan, Claimant Attorneys

The carrier submitted to the Board claimant's claim for temporary disability and medical benefits allegedly relating to an October 30, 1961, industrial injury. Claimant's doctor recommended left ankle surgery. The carrier recommends against reopening the claim for benefits on the ground that, on the date of injury, the employer did not have workers' compensation insurance coverage. The carrier contends, therefore, that the Board does not have jurisdiction of the claim.

On the date of claimant's industrial injury, former ORS 656.024 permitted an employer who is engaged in a hazardous occupation to reject worker's compensation insurance coverage by filing a written notice of rejection with the State Industrial Accident Commission, the Board's predecessor. See Or Laws 1959, ch 448, 2. At that time, logging was deemed a hazardous occupation. See Or Laws 1959, ch 448, 10. In the event an employer was engaged in a hazardous occupation and rejected coverage under former ORS 656.024, the employer was liable for an injury to a worker caused by the employer's negligence, default or wrongful act "as if [the workers' compensation] statutes had not been passed." Or Laws 1959, ch 448, 2. Moreover, the worker was not entitled to benefits afforded under the Workers' Compensation Act. See Nadeau v. Power Plant Engr. Co., 216 Or 12, 18 (1959).

Our review of the files of the Department of Insurance and Finance reveals no evidence that the employer had no workers' compensation coverage on the date of claimant's injury. We cannot assert our jurisdiction of claimant's claim unless the employer had coverage. Because there is no evidence that the employer

had coverage on the date of claimant's injury, we do not find that we have jurisdiction here. Accordingly, claimant's request for own motion relief is dismissed.

IT IS SO ORDERED.

April 10, 1991 Cite as 43 Van Natta 871 (1991)

In the Matter of the Compensation of
JAMES E. BLACKWOOD, JR., Claimant
WCB Case No. 89-21907
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Westerband and Myers.

The SAIF Corporation requests review of that portion of Referee Galton's order which granted claimant permanent total disability, for an upper back, shoulders and neck injury, whereas a Determination Order had awarded 17 percent (54.4 degrees) unscheduled permanent disability. On review, the issue is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

In 1968, claimant sustained a compensable injury to his low back. As a result of the injury, he underwent a laminectomy and fusion at L5-S1. He was ultimately awarded 30 percent unscheduled permanent disability as a result of this injury. In October 1981, claimant sustained a compensable injury to his neck. As a result of this injury, claimant was awarded 35 percent unscheduled permanent disability.

In 1985, claimant began working for the instant employer as a truck driver. In August 1987, he sustained a compensable injury to his neck, shoulders and upper back. Following this injury claimant began to experience psychological problems. He also lost approximately 100 pounds. Claimant was diagnosed as having major depression and chronic pain syndrome. SAIF accepted claimant's psychological condition as part of his compensable injury.

On March 17, 1989, claimant was hospitalized at Dammasch State Hospital due to alcohol intoxication, adjustment disorder with depressed mood and homicidal and suicidal ideation. On May 13, 1989, claimant was hospitalized following a suicide attempt. Thereafter, he entered an alcohol abuse program where he remained until June 20, 1989. In May 1989, claimant began attending Alcoholics Anonymous weekly meetings. However, claimant occasionally missed his Alcoholics Anonymous weekly meetings.

Claimant began receiving vocational assistance in April 1989. However, the vocational assistance was terminated in September 1989 due to claimant's psychological and alcohol problems. At the time his vocational assistance was terminated, his vocational counselor erroneously assumed that claimant's psychological condition was not a part of his compensable claim. On September 23, 1989, claimant was once more hospitalized due to an overdose resulting from alcohol and anti-depressant medication after learning that his vocational assistance had been terminated. Shortly thereafter, he voluntarily began alcohol and drug treatment through the Clackamas County Mental Health Center.

Following termination of his vocational services, claimant sought work as a dishwasher, service station attendant and machinist. Claimant also attempted to seek work as a security guard by accompanying a nightwatchman friend to work attempting to perform the friend's duties. Claimant's attempts at reemployment were unsuccessful.

Claimant's claim was closed by an October 1989 Determination Order which awarded 17 percent unscheduled permanent disability for his injury and psychological condition. This award took into account claimant's prior award of 35 percent unscheduled permanent disability for his 1981 compensable neck injury.

Claimant is 45 years old and has a seventh grade education. His reading comprehension is at a fifth grade level. He previously had some training as a welder and machinist, but did not complete the course in either occupation. He has previously worked as a truck driver, farm laborer and machinist.

As a result of his compensable injury and prior compensable injuries, claimant is physically limited to sedentary to light work. Claimant's physical disabilities in conjunction with his compensable psychological condition, limit him to sedentary work in a sheltered, structured environment. As a result of his compensable psychological condition, claimant is prescribed anti-depressants. This medication makes him drowsy and impairs his coordination and ability to concentrate.

FINDINGS OF ULTIMATE FACT

As a result of his compensable injury, preexisting disabilities, compensable psychological condition and relevant nonmedical factors, claimant is unable to obtain and hold gainful employment in the normal labor market.

Claimant is willing to seek work and has made reasonable efforts to obtain employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was permanently and totally disabled. Although we reach the same conclusion, we do so on the basis of a different analysis.

To establish his entitlement to permanent total disability, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Psychological conditions which are due to the compensable injury are considered with physical impairment in determining if an injured worker is permanently and totally disabled. Gornick v. SAIF, 92 Or App 303 (1988). Alternatively, permanent total disability may be established by evidence that the physical impairment, combined with certain social and vocational factors, effectively prevents gainful employment under the "odd-lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984), rev den 298 Or 470 (1985).

Dr. Mullins, claimant's treating chiropractor, opined that claimant could not return to his work as a truck driver. He further opined that as a result of the 1987 compensable injury and prior compensable injuries, claimant was now permanently limited to work in a sedentary to light capacity. There is no contrary opinion as to claimant's residual physical capacities. Accordingly, we conclude that he is physically capable of performing sedentary to light work.

Although claimant is physically capable of performing sedentary to light work, he also suffers from a compensable psychological condition which must be considered in addition to his physical impairment.

Claimant suffers from major depression and chronic pain syndrome. As a result of his psychological condition, he takes anti-depressants which cause drowsiness as well as impaired coordination and functioning. Both his depression and the anti-depressant medication impair claimant's ability to concentrate. When claimant's physical limitations are considered in conjunction with his psychological disability, he is limited to a sedentary work in a sheltered,

structured environment. We conclude therefore that claimant, although significantly disabled, is capable of limited sedentary work.

We next turn to the nonmedical factors. Claimant is 45 years of age and has a seventh grade education. He attempted courses in welding and machine work, but was unable to complete either course. His past work history consists of truck driving, farm work and machine work.

Richard Ross, vocational expert, interviewed claimant three times and conducted vocational testing. He reported that there were no unskilled entry level jobs in the state which matched claimant's primary aptitudes, skills and abilities. He opined that claimant was currently unable to work competitively or sell his services in the labor market. He based his opinion on claimant's physical limitations, impaired concentration, academic limitations, below competitive work pace and his lack of transferable vocational aptitudes. Mr. Ross' opinion is consistent with earlier vocational testing performed by Lagemen and Associates.

Joel A. Hughes, also a vocational expert, reviewed the record, but did not interview claimant or perform any testing. He opined that claimant was employable on the basis that claimant could benefit from further vocational assistance. Hughes did not believe that claimant had substantial psychological impairment. Finally, Hughes analogized the side effects of claimant's antidepressants with similar side-effects caused by over-the-counter allergy medication and opined that such side-effects did not necessarily impede work.

We find Mr. Ross' opinion persuasive. He interviewed claimant and performed independent testing. Further, his opinion is well-reasoned and consistent with both the medical evidence as well as prior vocational evidence. By contrast, Mr. Hughes only reviewed the record and did not interview or test claimant. Moreover, his opinion is based on his interpretation of medical evidence which is not consistent with the interpretation provided by medical experts. Finally, his opinion is also premised on claimant's employability with further training which does not address the issue of whether claimant is presently employable. See Gettman v. SAIF, 289 Or 609 (1980).

Under these circumstances, claimant has established that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Although claimant has established that he is presently permanently incapacitated from performing regular employment, he must also show that he is willing to seek work and has made reasonable efforts in this regard. See ORS 656.206(3).

Following his injury, claimant participated in vocational rehabilitation until it was erroneously terminated by SAIF. After vocational services were terminated, claimant attempted to become reemployed on his own and looked for work as a service station attendant, dishwasher, and machinist. He also spent a few nights testing his abilities as a nightwatchman with a friend who held such a position. However, claimant was unable to find employment. We conclude that claimant is willing to seek work and has made reasonable efforts to find work.

Finally, with regard to claimant's alcoholism, we agree with and adopt the Referee's discussion of this issue as set forth in in the third and fourth paragraphs on page six of his order.

Accordingly, claimant has established that he is permanently and totally disabled.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the permanent total disability issue is $2,000, to be

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

ORDER

The Referee's order dated April 5, 1990 is affirmed. For services on review concerning the permanent total disability issue, claimant's counsel is awarded an assessed attorney fee of $2,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
DALE A. COOMBE, Claimant
WCB Case No. 90-03120
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Mongrain's order that found that the SAIF Corporation had correctly calculated his temporary disability benefits. On review, the issue is the rate of temporary disability benefits. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as our own.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion" and "Conclusion of Law" concluding that SAIF correctly calculated claimant's rate of temporary disability benefits. We make the following supplementation.

SAIF argues that the issue of the correct temporary total disability rate for claimant's April 1, 1986 injury is barred by res judicata. SAIF contends that the calculation of claimant's rate of temporary disability benefits was essential to the determination of the issues presented to Referee Brown, which resulted in an April 28, 1989 Opinion and Order. We disagree.

The issue presented before Referee Brown was not the rate of claimant's temporary disability compensation. Instead, the issues included whether claimant's self-employment income represented "wages," and what, if any, penalties and attorney fees were due claimant. Therefore, we conclude that Referee Brown's finding regarding the proper temporary disability rate was not essential to the outcome of that hearing. Consequently, we conclude that res judicata does not bar claimant from seeking review of the method of calculating temporary disability compensation.

ORDER

The Referee's order dated July 20, 1990 is affirmed.

In the Matter of the Compensation of
ROBERT J. HUGHES, Claimant
WCB Case Nos. 90-00535 & 89-17295
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Dan DeNorch (Saif), Defense Attorney
Cooney, et al., Defense Attorneys

Reviewed by Board Members Myers and Westerband.

The SAIF Corporation requests review of Referee Bethlahmy's order that: (1) set aside its responsibility denial for claimant's carpal tunnel condition; and (2) upheld Giesy, Greer & Gunn's denial of responsibility for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The issue is which of two successive carriers is responsible for claimant's carpal tunnel syndrome. Because work for either of the carriers' insureds could have caused the condition, the Referee concluded that the last carrier, SAIF, was responsible under the last injurious exposure rule. See Bracke v. Baza'r, 293 Or 239 (1982). On review, SAIF contends that the application of the last injurious exposure rule was unnecessary, because the first carrier, Giesy, Greer & Gunn, had accepted claimant's carpal tunnel syndrome when it accepted a prior claim. We agree.

In November 1988, while working as an auto detailer for Giesy, Greer & Gunn's insured, claimant filed a claim seeking compensation for "torn nerves and ligaments" in his right arm. On the claim form, he reported that his arm had become swollen and numb after an extended period of polishing cars. Giesy, Greer & Gunn accepted the claim on January 25, 1989.

There is no evidence that, in accepting the November 1988 injury, Giesy, Greer & Gunn actually accepted claimant's bilateral carpal tunnel syndrome. The occupational disease was not diagnosed until six months after it had issued the notice of acceptance. See Johnson v. Spectra Physics, 303 Or 49 (1987). The question remains, however, whether Giesy, Greer & Gunn accepted the condition by virtue of having accepted symptoms of the disease.

The court recently addressed an analogous situation in SAIF v. Abbott, 103 Or App 49 (1990). In that case, the claimant sustained a work-related injury initially diagnosed as a wrist sprain and arm strain and filed a claim for those conditions. On the claim form, he described his injury as involving swelling, aching and hand numbness. His condition was not diagnosed as carpal tunnel syndrome until after the injury claim was accepted.

The insurer in that case argued that it accepted the injury as a right wrist strain and right shoulder strain and that that was not an acceptance of the carpal tunnel syndrome. The court disagreed. Relying on Georgia Pacific v. Piwowar, 305 Or 494 (1988), the court first noted that an acceptance of the compensability of specific symptoms includes acceptance of the compensability of the disease causing those symptoms. SAIF v. Abbott, supra at 53. Because the insurer had accepted the claimant's condition involving upper extremity swelling, aching and hand numbness, the court concluded that the insurer's acceptance

encompassed the disease causing those symptoms, which turned out to be carpal tunnel syndrome. Id. at 54.

We conclude that the same reasoning applies here. Giesy, Greer & Gunn accepted claimant's condition involving upper extremity swelling and numbness. Accordingly, Giesy, Greer & Gunn's acceptance of claimant's symptoms also encompassed the disease causing those symptoms, which, like in SAIF v. Abbott, supra, turned out to be carpal tunnel syndrome. We therefore proceed with our responsibility analysis.

In cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility is fixed with the carrier that initially accepted the claim. In order to shift responsibility, the prior carrier must prove affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. See Hensel Phelps v. Mirich, 81 Or App 290 (1986); Linda L. Wise, 42 Van Natta 115 (1990).

After our de novo review of the record, we conclude that Giesy, Greer & Gunn has failed to show that there was an independent contribution to the worsening of claimant's carpal tunnel syndrome while SAIF was on the risk. The only expert opinion introduced on this matter came from Dr. Hill, who stated only that claimant's symptoms have worsened. Consequently, Giesy, Greer & Gunn is the responsible carrier for claimant's compensable carpal tunnel syndrome.

ORDER

The Referee's order dated April 20, 1990 is reversed. Giesy, Greer & Gunn's responsibility denial for claimant's carpal tunnel condition is set aside and the claim is remanded to it for processing according to law. SAIF's denial of responsibility for the same condition is reinstated and upheld. Giesy, Greer and Gunn is responsible for the $1,650 attorney fee awarded to claimant's counsel by the Referee. Giesy, Greer and Gunn shall reimburse SAIF for any reimbursement it provided to Giesy, Greer and Gunn as a result of the Referee's order.

In the Matter of the Compensation of
CLEO I. BESWICK, Claimant
WCB Case No. 86-00108
ORDER ON REMAND
W. D. Bates, Jr., Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Beswick, 104 Or App 494 (1990). Relying on SAIF v. Stephen, 308 Or 41 (1989), the court concluded that our prior order, which affirmed a Referee's award of permanent total disability, Cleo I. Beswick, 41 Van Natta 1982 (1989), failed to make findings concerning whether claimant was willing to seek work. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation.

Claimant was 68 years old at the time of hearing. Her formal education includes a high school degree and a nine month clerical skills course. In addition, claimant has taken approximately two years of college courses.

Claimant has work experience as a retail salesperson, tailor, clerical worker and bookkeeper. She and her husband have owned several businesses, including three restaurants, a grocery store and a ranch. Claimant worked for the employer for six years in the capacity of payroll assistant. Her work included preparing records and entering data into a computer.

In December 1984, claimant compensably injured her neck while lifting a computer printout. Although she experienced neck and arm symptoms as a result of the injury, claimant remained at work. In March 1985, however, she left work due to her disabling symptoms. In June 1985, claimant applied for disability retirement benefits.

In August 1985, claimant underwent surgery at the C5-6 and C6-7 levels. Following surgery, she continued to experience neck pain radiating into her hands and arms. Claimant was found medically stationary in November 1985, although her treating doctor referred her for physical therapy at that time.

Claimant returned to modified, part-time work with the employer on March 4, 1986. The next day, claimant met with her supervisor and told her that she could not continue working because of severe pain.

On March 26, 1986, claimant's treating doctor, Dr. Reeves, D.O., reported that claimant had intractable pain and he referred her to the Injured Workers' Program. In April 1986, evaluators for the Program determined that claimant would be able to perform "conditionally sedentary" work for no more than two hours per day. Dr. Lakehomer, a psychologist for the Workers' Program, examined claimant and found her condition unremarkable with no formal diagnosis.

Following the evaluation by the Program, Dr. Reeves determined that claimant was unable to work because of her neck pain. He subsequently recommended participation in a pain clinic.

In April 1987, claimant had reduced range of motion of the lumbar spine. She had the capacity for only mild sedentary work for less than four hours a day. In May 1987, Dr. Reeves prescribed physical therapy for claimant to help her function in normal daily activities and to return to work if possible.

A July 13, 1987 Determination Order increased claimant's total unscheduled permanent disability award to 25 percent.

In January 1988, Dr. Reeves reported that claimant's condition remained unchanged and she was unable to return to work because of her age and physical condition.

Claimant was willing to seek work. But for her compensable injury, she would have returned to her work with the employer. Because of her disabling compensable condition, significant physical limitations, limited transferable skills and advanced age, it would have been futile for claimant to seek further employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, although claimant was not completely incapacitated on a physical basis, other factors combined with her physical disabilities to result in permanent total disability. We agree.

In order to prove entitlement to permanent total disability benefits, claimant must prove that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when

combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market." Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977).

Unless claimant's physical incapacity in conjunction with her nonmedical disabilities renders a work search futile, SAIF v. Scholl, 92 Or App 594, 597 (1988), she must also establish that she has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3). Moreover, even if a work search would be futile, she must further establish that, but for the compensable injury, she would have returned to work. SAIF v. Stephen, 308 Or 41, 47-48 (1989).

Following claimant's neck surgery, Dr. Paxton, claimant's treating surgeon, noted a "tremendous functional overlay element." Claimant's treating doctor, Dr. Reeves, has reported that claimant is capable of only mild sedentary work of a limited nature and for less than four hours a day. In addition, Dr. Lechner, a psychologist with the Pain Therapy Clinic, evaluated claimant and diagnosed anxiety and reactive depression secondary to her industrial injury. Dr. Lechner concurred with Dr. Reeves' opinion that claimant could only return to a very light and limited job.

The Referee concluded that claimant's age of 68 years, her severe physical disability resulting from her industrial injury and her functional overlay or chronic pain syndrome had combined to make a work search futile. We agree. Although the doctors have agreed that claimant could return to sedentary work, claimant's age, work restrictions and limited ability to work for more than a few hours each day would make any job search futile.

Although a work search by claimant would be futile, she is nonetheless required to establish that, but for the compensable injury, she would be willing to seek employment. SAIF v. Beswick, supra. In the present case, the record shows that claimant was willing to return to work. Following her surgery, claimant was interviewed by Cascade Rehabilitation Counseling. The vocational counselors reported that claimant greatly enjoyed her job and she indicated that she "was most anxious to return to work." The counselors reported that claimant was "willing to cooperate in any way she can to facilitate that return to work."

In March 1986, claimant returned to modified work with the employer. Although she completed her scheduled hours, the next day she met with her supervisor and informed her that she would be unable to continue, due to the pain she was experiencing. In April 1986, the Injured Workers' Program reported that, although claimant expressed a desire to return to work, her "feasibility to be successful is questionable."

In June 1986, Dr. Lakehomer, psychologist, examined claimant and reported that she "did not appear to be fully prepared for eliminating work and beginning retirement."

In November 1987, claimant was examined by BBV Medical Services. At that time, claimant reported that occasionally, she still "gets the feeling she would like to return to her old job...." In January 1988, claimant's vocational counselors noted that claimant "reports that she would be interested in returning to work (however), she feels so extremely physically limited that even the most sedentary/light positions are considered by her to be beyond her physically (sic) abilities."

At hearing, claimant testified that, when she returned to work following her injury, she hoped she could be able to do the work, although she was not

surprised that she could not. Claimant indicated that she would like to work if possible. Although a co-worker testified that claimant told her she was planning to retire in one to two years, claimant disputed that testimony and stated that she had no plans to retire.

We conclude that claimant has established that, but for her compensable injury, she would be willing to seek work. In reaching this conclusion, we rely on claimant's reports to her doctors and examining physicians, as well as uncontradicted reports from vocational counselors, her attempt to return to work in March 1986 and her testimony at hearing. In light of these consistent reports from a variety of sources, the co-worker's testimony concerning claimant's retirement plans does not cause us to alter our conclusion that claimant was willing to seek work but for her compensable injury. Accordingly, we conclude that claimant has sustained her burden of establishing that she is permanently and totally disabled as of February 7, 1987. Consequently, as supplemented herein, we adhere to and republish our November 6, 1989 order in its entirety.

IT IS SO ORDERED.

April 11, 1991 Cite as 43 Van Natta 879 (1991)

In the Matter of the Compensation of
CHARLES W. CULLMER, Claimant
WCB Case No. C1-00743
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Black, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

On April 1, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a non-stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, claimant has simultaneously submitted 13 separate and distinct claim disposition agreements, to include the above-captioned claim. All the agreements, including this one, provides that the amount of consideration is the "confidential settlement of the Jackson County Civil Case No. 90-4148-L." As such, we find that the proposed agreement fails to provide the specific amount of consideration. See Jerry H. Foss, 43 Van Natta 48 (1991); OAR 438-09-020(1)(a). Further, the agreement fails to provide the specific amount of the attorney fee. See OAR 438-15-052. Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS A. FACHET, Claimant
WCB Case No. 90-02880
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Brown's order that set aside its denial of claimant's medical services claim for an exercise program. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's supervised therapeutic exercise program was compensable. SAIF argues that the program is not compensable under three separate administrative rules. Although we do not agree that all three rules cited by SAIF are applicable in this case, we agree that the exercise program is not compensable.

Former OAR 436-10-050(2)

SAIF argues that athletic club memberships are subject to this rule, which requires the attending physician to maintain direct supervision or control over treatment provided by non-licensed providers. SAIF contends that "direct control and supervision" means the doctor is on the same premises, at the same time as the person providing the medical service ordered by the doctor.

In the present case, SAIF argues that the record does not show that the exercise program would be carried out by a licensed medical provider. SAIF also asserts that there is no evidence that Dr. Ewald would maintain direction or control over the program. Finally, SAIF notes that the exercise program would not take place on the premises where Dr. Ewald works.

We agree with SAIF's argument that former OAR 436-10-050(2) applies in the present case. In previous cases, we have found that athletic club memberships for purposes of swimming therapy are subject to former OAR 436-10-050(2). See Marilyn A. Robinson, 41 Van Natta 2104 (1989). We conclude that the exercise program at issue is comparable to an athletic club membership for swimming and is, therefore, subject to the same administrative rule. Because we are unable to find evidence that Dr. Ewald maintained any direction or supervision over the prescribed exercise program, we conclude that claimant has failed to prove that it is compensable.

Former OAR 436-10-040(4)(a)

SAIF argues that this rule provides that physical therapy may not be reimbursed unless carried out under a written treatment plan completed by the attending physician. SAIF contends that the definition of physical therapy includes exercise. SAIF argues that the exercise program is not compensable as the Referee found that Dr. Ewald did not provide a treatment plan as required by this rule.

We disagree with SAIF's argument that former OAR 436-10-040(4)(a) is applicable in this case. We conclude that an exercise program is distinguishable from physical therapy for purposes of the administrative rule.

OAR 436-10-040(8)

Under this administrative rule, trips to spas, rest areas or retreats are not reiumbursable unless special medical circumstances are shown to exist. Here, SAIF argues that prior Board cases have held that use of the facilities at a public YMCA and a private spa were encompassed in the term "trips to spas."

We agree that OAR 436-10-040(8) is applicable in this case. We have previously found that the rule applies to swim therapy. See Thomas H. Steward, 43 Van Natta 189 (1991). Accordingly, we conclude that the rule also applies to the exercise program prescribed in the present case. We are unable to find evidence that special medical circumstances exist to justify claimant's membership or exercise program at the fitness center.

ORDER

The Referee's order dated June 28, 1990 is reversed. The SAIF Corporation's December 15, 1989 denial is reinstated and upheld. The Referee's award of an assessed attorney fee of $750 is also reversed.

April 11, 1991 Cite as 43 Van Natta 881 (1991)

In the Matter of the Compensation of
BETTY S. FRANKLIN, Claimant
WCB Case No. 89-13985
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

On March 15, 1991, we abated our February 27, 1991 Order on Review. We took this action in response to claimant's contention that this matter had been resolved by the parties. The insurer was granted an opportunity to respond to claimant's contentions within 10 days of our abatement order. No further response has been received.

Enclosed with claimant's motion for reconsideration was a copy of a "Disputed Claim Settlement" resolving issues pending before the Board in this matter, in lieu of the Referee's order, as well as issues pending before the Hearings Division in WCB Case No. 90-12009. Those portions of the settlement which pertain to the Hearings Division have received Referee approval. By this order, we have approved those portions of the parties' disputed claim settlement which pertain to issues pending review, thereby fully and finally resolving this matter, in lieu of the Referee's order.

Furthermore, on April 4, 1991, we approved the parties' claim disposition agreement, in which claimant agreed to fully release her right to future workers' compensation benefits, except medical services, for her compensable injury. WCB Case No. C1-00493. Pursuant to the claim disposition agreement, the parties agreed that all issues which were either raised or could be raised between them were fully settled.

In light of our approval of the disputed claim settlement and claim disposition agreement, the request for Board review is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
BONNIE L. GLAZE, Claimant
WCB Case No. 89-02206
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee McWilliams' order that increased claimant's unscheduled permanent disability award for a low back injury from 30 percent (96 degrees), as awarded by a Determination Order, to 34 percent (108.8 degrees). In addition, claimant objects to the Referee's exclusion from the record of a medical exhibit submitted posthearing. On review, the issues are evidence and extent of unscheduled permanent disability. We affirm on the evidentiary issue and modify on the extent issue.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant's employment as a movie "extra" required only that she sit and walk and did not involve any lifting.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant contends on review that the Referee improperly refused to admit into the record a written report dated June 13, 1989, from Dr. Wallace, claimant's treating orthopedic physician in California. That report was received by the self-insured employer on June 23, 1989, the same date as the hearing in this matter. A copy of this report was forwarded to claimant's counsel and received on June 28, 1989. At the time of the hearing, the record was held open for the submission of additional evidence regarding time loss benefits and associated attorney fees. The record was closed on August 25, 1989. By letter dated December 15, 1989, claimant submitted the report to the Referee for inclusion in the record. The Referee declined to reopen the record to admit the report.

There is no question here regarding timely disclosure of the report by the employer to claimant. In this regard, the employer provided the report to claimant within 5 days of receipt. See OAR 438-07-015(4). By the time claimant submitted the report for admission, claimant had possessed the report for nearly six months and the evidentiary record had been closed for nearly four months. Under the circumstances, we conclude that the Referee did not abuse her discretion by refusing to reopen the record in order to admit the evidence. See OAR 438-07-025. In addition, we conclude that, in the absence of the report, the record has not been "improperly, incompletely or otherwise insufficiently developed" so that, pursuant to ORS 656.295(5), remand would be appropriate.

Extent of Permanent Disability

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to former ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). The self-insured employer argues that the "standards" effective January 1, 1989 apply to the rating of claimant's disability. We do not agree. Those "stand-ards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010(1). In this case, the "standards" adopted effective July 1, 1988 (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 57 years is 1. Former OAR 436-35-290.

Formal education

Claimant did not complete all of the credit requirements for graduation from high school. The appropriate value for claimant's 11 years of formal education is 1. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 3 as a courtesy clerk (DOT #290.477-018) and house worker (DOT # 301.474-010). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5).

Claimant's total education value is 5, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

Under former OAR 436-35-310, adaptability values range from 0 to 8. No adaptability value is given to a claimant who has returned to her usual and customary work, or accepted a work offer for usual and customary work, or who has received a "work offer" for usual and customary work but who has refused or has not responded to the "work offer." Former OAR 436-35-310(2)(a) & (b). An

adaptability value for a claimant who is unable to return to her usual and customary work but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d). If, as a result of the injury, a claimant is not working and no employment has been offered, the adaptability factor shall be based on residual physical capacity according to the table in former OAR 436-35-310(4).

Here, the Referee concluded that claimant was employed in modified work as a movie "extra" and, therefore, she arrived at claimant's adaptability factor utilizing subsection (3) of former OAR 436-35-310. Claimant contends that her adaptability factor should be arrived at by utilizing subsection (4) of the rule. She argues that her work as a movie "extra" was sporadic and, in addition, that she was not so employed as of the date of hearing. We conclude, however, that the Referee's use of subsection (3) of the rule was proper.

"Modified work" as used in the standards is defined as "some job other than the job held at the time of injury, or the job held at the time of injury with any modification of duties." Former OAR 436-35-270(3)(b). The "standards" neither state nor suggest that employment which is sporadic in nature is not to be considered "modified work." Further, there is no indication here that claimant worked only sporadically due to the effects of her compensable injury. Similarly, the fact that claimant was not working as an "extra" on the date of hearing, for reasons unrelated to her compensable injury, does not negate application of subsection (3) of the rule. See Joyce M. Ramirez-Jones, 43 Van Natta 342 (1991) (Subsection (3) of former OAR 436-35-310 applied to injured workers who returns to seasonal work following injury but is unemployed at hearing.) Therefore, we conclude that claimant's adaptability factor is properly determined under former OAR 436-35-310(3)(a).

Claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work as a movie "extra" required a sedentary physical capacity. Therefore, her adaptability value is 3.

Impairment

The Referee awarded claimant an impairment value of 5 percent for claimant's laminectomy with single discectomy. We agree. Former OAR 436-35-350(2).

In addition, the Referee awarded claimant 4 percent each for unoperated disc derangements with clinically-related symptoms at three levels: L2-3, L3-4 and L5-S1. The Referee added these 4 percent values to arrive at a cumulative value of 12 percent. We agree. Further, the 12 percent value for disc derangement is added to the 5 percent value for spinal surgery, for a total of 17 percent. Leland M. Pollock, 42 Van Natta 925 (1990).

The Referee also awarded claimant an impairment value of 10 percent for disabling pain. Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. In Daniel M. Alire, 41 Van Natta 752 (1989), we held that, inasmuch as the "standards" do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensated him for his loss of use or function attributable to the disabling pain.

The employer argues that, because the Referee found claimant's testimony to be unreliable, it was not proper to award claimant a value for disabling pain. We have adopted the Referee's finding that claimant is not reliable. However, we conclude, as did the Referee, that sufficient reliable evidence exists in the record from which to conclude that claimant does have loss of use or function due to pain to support an award under former OAR 436-35-320(1)(a). We adopt the Referee's discussion of this issue. Moreover, we further conclude that the 10 percent value assigned by the Referee appropriately measures that loss of use.

The Referee did not award a value for lost range of spinal motion. Claimant argues for such an award, noting that Dr. Wallace reported in his closing examination that claimant reached to her knees upon forward flexion. However, other than noting claimant's reports of pain, Dr. Wallace does not expressly attribute claimant's limited forward flexion to her compensable condition. Further, while claimant's lack of reliability does not negate a general finding of loss of use due to pain, her unreliability does call into question any specific finding regarding a one-time loss-of-motion measurement. Moreover, even if we were to accept Dr. Wallace's report as establishing injury-related loss of forward flexion, we still lack a measurement of that loss in terms of degrees. In sum, we agree with the Referee that claimant has failed to establish entitlement to an impairment value for lost range of motion due to her injury.

The impairment values for claimant's surgery and disc derangements, 17, and disabling pain, 10, are combined for a total impairment value of 25.3 percent (to the nearest 1/10th of one percent).

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to her education value, 5, the sum is 6. When that value is multiplied by claimant's adaptability value, 3, the product is 18. When that value is added to claimant's impairment value, 25.3, the result is 43.3 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 44 percent.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

Claimant argues entitlement to an increased award based upon clear and convincing evidence that she suffers from a chronic condition limiting repetitive use of her low back, and that she has lost approximately half of her preinjury capacity for stooping, lifting, pushing, pulling, climbing, and other physical activities. However, in light of claimant's unreliability, we cannot find that it is highly probable that claimant's permanent disability exceeds that indicated by the "standards."

The Referee reduced claimant's award by 5 percent, reasoning that claimant was 5 percent disabled immediately before this compensable injury as a result of a prior compensable injury to the same body part. The Referee relied upon ORS 656.214(5), which provides that an injured worker's award of compensation be "determined by the extent of the disability compared to the worker before such

injury and without such disability." The Referee concluded that the statute compels a comparison of claimant's disability before his compensable injury with the disability she had afterward. We agree. Mary A. Vogelaar, 42 Van Natta 2846 (1990). Accordingly, we find that the Referee properly reduced claimant's unscheduled permanent disability award by 5 percent. Accordingly, we conclude that claimant is entitled to an award of 39 percent for her 1987 low back injury.

ORDER

The Referee's order dated November 13, 1989, as amended February 8, 1990 and February 16, 1990, is modified. In addition to the Referee's award and the Determination Order award, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, for a total award of 39 percent (124.8 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fee allowed by the Referee and Board order shall not exceed $3,800.

In the Matter of the Compensation of
ROYLEE W. MARLOW, Claimant
WCB Case No. C1-00686
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Ackerman, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

On March 28, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, the proposed disposition fails to provide a prominent or bold face order paragraph. See OAR 438-09-020(1)(c). We also note that the agreement fails to provide the Director's approval, which is required because the claim is subject to reimbursement from the Re-employment Assistance Reserve.

Further, the stated consideration in the CDA was $6,000, although this amount appears to be subject to a mileage reimbursement overpayment in the amount of $115.20 (see page 6, line 3 of CDA). Thus, one could conclude that the actual consideration is $5,884.80, rather than $6,000. Moreover, assuming this to be the case, the stated attorney fee of $1,500 exceeds the amount allowed under OAR 438-15-052.

Inasmuch as the Board can not ascertain the amount of the consideration, and therefore cannot verify the attorney fee, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent

disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

April 11, 1991 Cite as 43 Van Natta 887 (1991)

In the Matter of the Compensation of
JAMES I. McCRACKEN, Claimant
WCB Case No. 90-03174
ORDER ON REVIEW
Westmoreland, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brittingham, Nichols, and Crider.

The insurer requests review of that portion of Referee Brazeau's order which increased claimant's scheduled permanent disability award for loss of use or function of the right leg from 5 percent (7.5 degrees), as awarded by a Determination Order, to 48 percent (72 degrees). On review, the issue is extent of scheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant's condition became medically stationary on October 5, 1989.

Claimant experiences mechanical instability of the right knee due to articular damage to the patellofemoral joint. Claimant has a limp as a consequence of his right knee injury.

FINDING OF ULTIMATE FACT

Claimant has sustained a 25 percent loss of use or function of his right leg as a result of his knee injury.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability Under the Standards

The Referee increased claimant's scheduled permanent disability award for his right knee/leg injury from 5 percent to 48 percent. On de novo review, we calculate a different value.

Claimant's condition became medically stationary on October 5, 1989, and his claim was closed by Determination Order on January 17, 1990. Therefore, we apply former OAR 436-35-001 et seq. Former OAR 438-10-010. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent disability. Former 436-35-010(1).

The Referee awarded a 42 percent value for lost knee motion, a 5 percent value for right thigh atrophy, and a 5 percent value for loss of repetitive use of the right knee/leg. He made no award for claimant's joint instability, surgeries or limp. The parties do not dispute that claimant is entitled to no value under the standards for his joint instability, limp or surgeries. The insurer

primarily challenges the award of 42 percent for lost range of right knee motion due to a brace. Therefore, we address only claimant's atrophy, loss of repetitive use of the right knee/leg due to a chronic condition, and loss of range of motion.

Atrophy

Claimant has one-half inch atrophy of the right thigh due to his right knee injury. Therefore, we agree claimant should receive an award of 5 percent impairment for atrophy. Former OAR 436-35-230(5)(b).

Loss of Repetitive Use

Claimant is permanently limited to light ambulatory activities. Furthermore, he is unable to repetitively kneel, stoop, squat, bend, or walk on inclines or uneven surfaces due to his right knee injury. Therefore, we agree with the Referee's award of 5 percent impairment for this loss. Former OAR 436-35-010(7).

Loss of Range of Motion

Finding that claimant has a mechanical instability of the right knee joint such that he must wear a knee brace that limits his flexion to 30 degrees, the Referee awarded claimant 42 percent for loss of range of motion under former OAR 436-35-220(1). We disagree. Under the standards, the movement of a joint is measured in active degrees of motion. Former OAR 436-35-010(3). Inasmuch as claimant's mechanical brace is a passive restraint, it prevents the measurement of active degrees of motion. Therefore, we conclude that the standards require measurement of claimant's knee motion without the brace. The closing examination performed by Dr. Gilsdorf, claimant's treating orthopedic physician, revealed that claimant has full range of motion of the right knee joint when he is not wearing the brace. Therefore, no impairment value is awarded under the standards for loss of right knee range of motion.

Accordingly, claimant's only ratable impairments under the standards are 5 percent for atrophy of the right thigh, and 5 percent for loss of repetitive use of the right knee/leg. Former OAR 436-35-230(5)(b); former OAR 436-35-110(7). When those values are combined, the total scheduled impairment value for claimant's right knee/leg is 9.75 percent. Former OAR 436-35-220(4). When that value is rounded up to the next higher whole percentage, claimant's permanent scheduled disability under the standards for loss of use or function of the right knee/leg is 10 percent. Former OAR 436-35-010(6).

Disability Outside the Standards

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). In examining for clear and convincing evidence, we view the record as a whole. Thomas L. Swanger, 42 Van Natta 887 (1990). Here, we find that claimant's impairment is greater than that indicated under the standards.

Claimant sustained a patellofemoral dislocation of the right knee joint requiring repair and debridement of the patellofemoral capsule. This surgery did not provide claimant pain relief and further surgery was undertaken with

excision of the synovial plica and shaving of the patellar surface. Neither surgical procedure is ratable under the standards.

Moreover, claimant continues to experience pain due to articular damage to the patella, most notably causing claimant to limp. Claimant's limp is not ratable under the standards either; yet due to ongoing mechanical instability of the patellofemoral joint, claimant has instability of the knee joint which has resulted in his falling and sustaining further injuries.

Claimant wears a knee brace prescribed by his treating physician to stabilize the knee joint. The mere fact that claimant wears a brace does not constitute clear and convincing evidence that his disability is greater than the award to which claimant is entitled under the standards. See Kirk A. Shira, 42 Van Natta 1011 (1990). The medical evidence must demonstrate that, as a result of the brace, claimant's disability is greater than that measured under the standards. See Edythe P. Eggleston, 42 Van Natta 1526 (1990) (no award outside the standards where alleged loss of motion not verified by physician). Here, the medical evidence establishes that claimant's brace reduces his knee flexion from the normal 150 degrees to 30 degrees. As discussed above, this loss of motion is not otherwise ratable under the standards.

We consider claimant's surgery, his residual pain, limping and instability, and both the positive effect of the brace in terms of increased stability and the negative effect in terms of lost range of motion. Based on these factors, we conclude there is clear and convincing evidence that the loss of use or function of claimant's knee/leg is greater than he would be awarded under the standards. Accordingly, we find that claimant is entitled to an award of 25 percent permanent disability for loss of use or function of his knee/leg.

ORDER

The Referee's order dated June 26, 1990 is affirmed in part and modified in part. In lieu of the Referee's award and in addition to the 5 percent (7.5 degrees) scheduled permanent disability awarded by the Determination Order, claimant is awarded 20 percent (30 degrees) scheduled permanent disability, giving him a total award to date of 25 percent (37.5 degrees) scheduled permanent disability for loss of use or function of the right leg. The remainder of the order is affirmed.

Board Member Crider, dissenting.

The Board errs in reducing claimant's award. The Board interprets former OAR 436-35-220(1) to require measurement of motion in the knee unimpeded by a knee brace even though the brace must be worn as a result of the compensable injury. Assuming this interpretation of the rule is correct, claimant has proven loss of use or function in excess not only of the 10 percent allowed by the standard, but also in excess of the 25 percent awarded by the Board.

Use of the brace, which is necessary due to knee instability, causes great reduction in range of motion. Noting claimant's knee instability, claimant's physician wrote that claimant was unable to tolerate sustained walking, squatting or high-paced activity. He wrote that, "Because of this knee injury, this man is limited to light ambulatory to sedentary activities, with a major loss of functional capacity relative to his previous physical capacities." To adequately compensate him for his condition, an award of no less than the 48 percent awarded by the Referee is appropriate.

In the Matter of the Compensation of
LINDA L. VALEK, Claimant
WCB Case No. 89-17628
ORDER ON REVIEW
Constance Crooker, Claimant Attorney
A. Gregory McKenzie, Attorney
Randolph B. Harris (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Neal's order which set aside its denial of claimant's claim for a migraine headache condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's migraine headache condition is compensable under former ORS 656.802(1)(c) because claimant has experienced a series of traumatic events or occurrences arising out of and in the course of her employment. We disagree.

Claimant alleges that psychological stress in her working environment caused her migraine headaches. Because claimant's last exposure to work stressors which could have caused her migraine headaches was in June 1989, the occupational disease law which became effective January 1, 1988 is applicable. See former ORS 656.802; Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986).

In pertinent part, former ORS 656.802(1)(c) defines occupational disease as:

> "Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability."

The Board concluded in Ronald V. Dickson, 42 Van Natta 1102 (1990), that the legislature intended paragraph (c) of former ORS 656.802(1) to encompass only a series of "physical" traumatic events rather than series of "psychological" traumatic events. Claimant does not argue nor provide evidence of any series of traumatic events or occurrences other than a stressful work environment. Accordingly, we conclude that former ORS 656.801(1)(c) is not applicable in the present case.

There is no claim or evidence that claimant's headaches were caused by working conditions which included ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation, or other toxic or contact-type conditions. See Dickson, supra at 1106. Accordingly, claimant's headaches have not been shown to be a compensable occupational disease under former ORS 656.802(1)(a).

In Dickson, supra at 1108-09 we held:

> "Physical conditions resulting from work-related 'stress' are not compensable under paragraph (b), unless a 'mental disorder' has been diagnosed as

> the underlying condition. Only in that situation, where physical condition directly result from a diagnosed mental disorder, can a stress-related physical condition be found compensable under [former] ORS 656.802(1)(b) and (2)."

Here, claimant allegedly experienced work-related stress which began in the Fall of 1988 and continued until June 1989 allegedly causing her to experience migraine headaches for which she has a history. Claimant argues that because a migraine headache condition is recognized in the medical community and occurs in the brain, it is, by definition a mental disorder. However, the issue is whether the medical or psychological communities recognize claimant's medical condition as a "mental disorder." Claimant provides no evidence to support that proposition. Accordingly, we conclude that claimant has not met her burden of proof to determine that she has a "mental disorder" arising out of and in the course of her employment. Thus, claimant's headaches are not a compensable occupational disease under former ORS 656.802(1)(b).

Claimant has shown that job stress probably precipitated her migraine headaches. However, because her work-related stress is not properly characterized as a substance or condition of the type included in ORS 656.802(1)(a), did not result in a mental disorder, and was not a series of traumatic events, claimant has not proven a compensable occupational disease under former ORS 656.802.

ORDER

The Referee's order dated April 30, 1990 is reversed. SAIF's denial is reinstated and upheld.

Board Member Howell, concurring.

Because of this Board's holding in Ronald V. Dickson, 42 Van Natta 1102 (1990), I must concur.

April 12, 1991 Cite as 43 Van Natta 891 (1991)

In the Matter of the Compensation of
MARGARET A. AGNER, Claimant
WCB Case No. 89-24862
ORDER ON REVIEW
Francis & Martin, Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Cushing.

Claimant requests review of Referee Myzak's order that: (1) upheld the insurer's denial of claimant's cervical condition; and (2) found that claimant's claim was not prematurely closed. In a separate motion, claimant has also requested that her hearing be reopened with regard to the insurer's partial denial of her back condition. Inasmuch as this case is on review, we have interpreted the request as a motion to remand for the introduction of additional evidence. ORS 656.295(5). On review, the issues are remand, compensability and premature closure.

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

Prior to hearing, the insurer issued a partial denial of claimant's low back condition, asserting that it was not related to her accepted right elbow laceration. (Ex. 15C-1). Claimant initially filed a supplemental request for hearing on that denial; however, she withdrew it as an issue at the June 27, 1990 hearing. (Tr. 3).

After the record had been closed, claimant requested that the hearing be reopened with regard to the denial of her back condition. Her attorney stated that, at the time of hearing, he was not aware that the back injury had occurred during the course of physical therapy and that the insurer's attorney, who had spoken with claimant's treating physician a few days prior to hearing, had failed to disclose that information. Claimant also enclosed a copy of her physician's chart note, dated August 13, 1990, which memoralized the events.

We may remand to the Referee for the taking of additional evidence if we determine that a case had been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, however, it must be shown that the evidence was not obtainable with due diligence before the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

We addressed a similar request for remand in Penni L. Mumm, 42 Van Natta 1615 (1990). In that case, the claimant asked the carrier at hearing to check its file because it appeared that the medical records that had been produced were incomplete. After the carrier responded that copies of its entire files had been provided, the record was closed. Thereafter, the claimant requested her medical records directly from the medical provider. When she received reports not previously provided to her or the insurer, she moved for remand.

We held that remand was appropriate under those circumstances. We reasoned that, if claimants' attorneys cannot be assured that they are exercising due diligence in obtaining medical reports when they rely on the disclosure provisions of OAR 436-10-030, then they will be forced to routinely request documents directly from the providers. Concluding that such a procedure would needlessly increase the cost of litigation, we declined to create such a situation.

Claimant contends that the same reasoning applies here. She argues that, as in Mumm, her attorney properly relied on written medical reports provided by the insurer pursuant to OAR 436-10-030. Although the insurer did not have a copy of the August 13, 1990 chart note at the time of hearing, claimant contends that the insurer's attorney was aware of the content of that chart note at that time because of his prior conversation with the treating physician. Therefore, claimant reasons that the omission of the evidence was occasioned not by negligent conduct on her part, but rather by the insurer's failure to disclose the information prior to hearing.

Claimant's reliance on Mumm is misplaced. As we noted in Mumm, medical care providers are required to regularly submit reports to insurers and, in turn, insurers are required to disclose such reports to injured workers and their attorneys. See OAR 436-10-030. Here, the insurer's attorney met with claimant's treating physician prior to hearing. However, he obtained no medical reports, nor were any documents generated as a result of their meeting. Therefore, he did not fail to comply with any rules relating to medical reporting and discovery. In addition, he was under no obligation to disclose the contents of any oral conversation that he had with the doctor.

Furthermore, claimant's attorney had the same opportunity to speak with claimant's treating physician prior to hearing as the insurer's attorney did. Yet, he chose not to avail himself of that opportunity. Thus, we find no reason

to conclude that an opinion of claimant's low back conditions was not obtainable with due diligence before the hearing. Claimant's request for remand is denied.

ORDER

The Referee's order dated July 27, 1990 is affirmed.

April 12, 1991 Cite as 43 Van Natta 893 (1991)

In the Matter of the Compensation of
JUDY ORR, Claimant
WCB Case No. 90-02622
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's denial of claimant's medical services claim; and (2) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable claims processing. On review, the issues are medical services, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a work-related injury in September 1985, when she fell during her employment as a bus driver. She filed a claim for neck and low back pain and resulting emotional depression. On November 11, 1985, SAIF accepted the claim as a disabling injury. By stipulation on March 25, 1988, SAIF and claimant agreed that claimant was entitled to 50 percent unscheduled permanent disability.

Claimant subsequently developed agoraphobia, the fear of the thought of being alone in a large open space, and sought to have her claim reopened. SAIF denied the claim. By stipulation approved April 7, 1989, however, SAIF rescinded its earlier denial and accepted responsibility for claimant's psychological condition.

Claimant lives in St. Helens, Oregon, and was treated by Dr. Garrison, a psychologist, for her agoraphobia. When Dr. Garrison closed his practice in St. Helens, he recommended claimant continue her treatment with Suzanne Linn, a St. Helens mental health counselor. On May 29, 1990, SAIF denied payment of Linn's services, stating that she was not a licensed physician or operating under the direct control of a physician. Claimant requested a hearing, challenging SAIF's denial and requesting a penalty and attorney fee.

CONCLUSIONS OF LAW AND OPINION

Medical Services

We adopt the Referee's conclusions and reasoning concerning the issue of medical services with the following comment.

At hearing, claimant testified that, after Dr. Garrison closed his practice, she called SAIF to inquire about the compensability of mental health counseling with Suzanne Linn. According to claimant, a claims examiner indicated that there was no problem and that the services would be paid under her workers'

compensation claim. Linn also testified at hearing. She stated that she had similarly contacted SAIF and was likewise assured that the services would be paid. On review, claimant relies on that testimony and argues that SAIF should be estopped from denying payment for the treatment.

The essential elements of estoppel are set out in Bennet v. City of Salem, 192 Or 531, 541 (1951):

> "To constitute an equitable estoppel, or estoppel by conduct, (1) there must be a false representation; (2) it must be made with knowledge of the facts; (3) the other party must have been ignorant of the truth; (4) it must have been made with the intention that it should be acted upon by the other party; and (5) the other party must have been induced to act upon it."

Estoppel is not available to an employer to defeat a claimant's right to compensation. Stovall v. Sally Salmon Seafood, 306 Or 25 (1988). The doctrine, however, may be asserted by a claimant against a carrier in the workers' compensation context. See Lamarr H. Barber, 43 Van Natta 292 (1991).

In this case, claimant contends that she relied on assurances, made by SAIF's representative, that her treatment with Linn would be covered. However, we find no evidence that the representation was made with knowledge of the facts. The record reveals that, when Linn called SAIF, she had inaccurately advised the claims representative that she worked under the direct supervision of a licensed physician. (Tr. 24). Thus, any assurance made by the representative that the treatment would be covered could not have been made with an accurate knowledge of the facts.

After our review of the record, we conclude that SAIF was not estopped from denying compensability of claimant's medical services claim; the Referee properly upheld SAIF's denial on that issue.

Penalty and Attorney Fees

We adopt the conclusions and reasoning concerning the penalty and attorney fee issue as set forth in the Referee's order.

ORDER

The Referee's order dated July 16, 1990 is affirmed.

In the Matter of the Compensation of
DENNIS R. SKYLES, Claimant
WCB Case No. 89-07317
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of that portion of Referee Harri's order that set aside its denial of claimant's occupational disease claim for a mental disorder. In his brief, claimant requests that we strike as irrelevant certain materials attached to SAIF's brief. In addition, in a supplemental

memorandum, claimant requests that the Board assess penalties and associated attorney fees for SAIF's allegedly unreasonable continuing denial. On review, the issues are claimant's motion to strike, compensability, and penalties and attorney fees. We deny the motion and affirm on the merits.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant's mental disorder required medical treatment and resulted in disability.

Employment conditions, which existed in a real and objective sense, contributed in material part to claimant's mental disorder.

The conditions which resulted in claimant's disabling mental disorder were not conditions generally inherent in every working situation; they were not disciplinary, corrective or job performance evaluation actions; and they were not associated with the cessation of employment.

Claimant's mental disorder is generally recognized in the pyschological community.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Attached to SAIF's appellant's brief are copies of several referees' orders dealing with unrelated claims for mental disorders. Claimant argues that these orders are irrelevant and that they should be stricken. Claimant alleges no prejudice as a result of the submission of these orders. Therefore, while our review is de novo and the referees' orders have no binding precedential effect upon us, we decline claimant's motion.

Compensability

We adopt the Referee's "Conclusions and Opinion" with the following supplementation.

The date of "injury" for purposes of determining the compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions that caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986). Here, claimant's occupational disease claim for his current psychological condition alleges exposure to potentially causal employment conditions occurring after January 1, 1988. Accordingly, the occupational disease law which became effective January 1, 1988, is applicable. See Johnson, supra at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

The applicable version of ORS 656.802 provides, in part, that an occupational disease arising out of and in the course of employment which requires medical services will not be compensable:

> "(2)(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> " (b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job

> performance evaluation actions by the employer, or cessation of employment.
>
> " (c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> " (d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

On review, SAIF does not challenge the Referee's conclusions with regard to the elements contained in subsections (a), (c) and (d) of ORS 656.802(2). SAIF argues only that claimant has failed to establish that the stressful conditions of his employment which caused his mental disorder are "other than conditions generally inherent in every working situation * * *." SAIF contends that, for purposes of deciding whether the stressful conditions are "generally inherent in every working situation," the conditions of claimant's employment are to be compared with those with whom he works, not with the entire work force. We do not agree. In Kathlene M. Payne, 42 Van Natta 1900 (1990), we rejected a contention that the comparison should be made with the conditions usually present in the employment environment peculiar to the claimant. We continue to hold that the phrase in question is directed to conditions which are presumed to be generally present in all jobs, not merely those peculiar to the claimant.

Moreover, the evidence establishes that the stress-producing conditions of claimant's employment are not generally inherent in every working situation. Dr. Worthington persuasively opined in this regard:

> "This man's position of managing a very large caseload of chronically mentally ill individuals is inherently among the most stressful of all social service jobs. * * *. It is virtually unheard of for one individual to serve as both program manager and primary service provider with little or no support from assistants or other case workers." (Ex. 124-4).

In addition, Dr. Worthington testified as follows:

> "Having worked in a wide variety of mental health settings * * * I personally have not been involved in any situation where there has been so little professional support." (Tr. 42).

Accordingly, even if we were to compare claimant's working conditions with those of other similarly situated workers, the evidence establishes that claimant's conditions of employment are not generally inherent in those working conditions.

Penalties and Attorney Fees

On review, claimant contends that, in light of the Board's decision in Kathlene M. Payne, supra, SAIF's continuing denial was unreasonable. Claimant has raised this ground for assessment of a penalty and related attorney fees in a supplemental memorandum filed with the Board after completion of the briefing schedule. As a policy matter, unless authorized, we will not consider supplemental argument presented after completion of the briefing schedule. The parties may, nevertheless, bring to the Board's attention recent decisions issued

after completion of the briefing schedule. Betty L. Juneau, 38 Van Natta 553 (1986), aff'd mem 85 Or App 219, rev den 303 Or 590 (1987).

Here, our decision in Payne was issued after completion of the briefing schedule. Therefore, claimant acted properly in bringing our decision in Payne to our attention with regard to the merits of the issue on review. However, we are unwilling to address a new ground for imposition of a penalty and related fee resulting from a decision in an unrelated matter which issues following completion of the briefing schedule. We note in particular that no procedure exists allowing for a response by SAIF to claimant's newly-raised argument. If claimant believes that SAIF's continuing denial in light of our decision in Payne warrants a penalty and related fee, then claimant should commence a new proceeding raising this as an issue. We decline to consider it at this stage of our review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $900, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 17, 1990 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed attorney fee of $900, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
LAWRENCE J. TAYLOR, Claimant
WCB Case No. 89-037055
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell and Crider.

The self-insured employer requests review of those portions of Referee Emerson's order which: (1) set aside its denial of claimant's claim for bilateral carpal tunnel syndrome; and (2) awarded claimant an assessed attorney fee for prevailing on the denial. Claimant cross-requests review of that portion of the Referee's order which declined to assess a penalty and related attorney for for an allegedly unreasonably late denial. On review, the issues are compensability, penalty and related attorney fees.

The Board affirms and adopts the order of the Refereee with the following supplementation.

The Referee concluded that because there was no delay in the payment of compensation to claimant, claimant was not entitled to an assessed penalty and related attorney fees for the employer's delay in processing claimant's claim. We agree.

Claimant argues without proof that there were bills due and owing as a consequence of the employer's delay in processing claimant's claim. However, without evidence of compensation due, no penalty may be assessed. ORS

656.262(10). Further, ORS 656.383(1) allows an attorney fee if an insurer "unreasonably resists the payment of compensation." Absent a showing that the employer's inaction affected some obligation to pay compensation due in the past, present or future, it cannot be said that there was any resistance to such payment. Buck E. Johnson, 43 Van Natta 423 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated April 20, 1990 is affirmed.

Board Member Crider, concurring in part and dissenting in part.

I concur with that portion of the order that concludes that the claim is compensable; I disagree, however, with that portion that concludes that claimant is not entitled to an employer-paid attorney fee under ORS 656.382(1).

Claimant filed a claim. The employer failed to timely accept or deny the claim. The claim is compensable. Ordinarily, such conduct is deemed a resistance to the payment of compensation and a fee is payable even though there are no amounts then due against which a penalty may be assessed. See e.g., Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989); Steve Chambers, 42 Van Natta 524 (1990); Cindi A. Cadieux, 42 Van Natta 2259 (1989).

Nevertheless, the majority holds that the employer did not resist the payment of compensation because claimant has not proven that medical bills were not paid before the denial issued. I am not persuaded that it matters whether or not bills have been paid. The purpose of the statutory requirement of prompt acceptance or denial is to put questions of compensability finally to rest soon after the claim is filed. Bauman v. SAIF, 295 Or 788 (1983). The mere payment of medical bills is not tantamount to acceptance. Ellis v. McCall Insulation, 308 Or 74 (1989). Thus, payment of medical bills does not serve the purpose of securing the right to future compensation under the workers' compensation law which ORS 656.262(6) is designed to achieve.

Because the failure to timely accept or deny the claim interfered with the interest in securing claimant's right to compensation, it is a resistance to the payment of compensation within the meaning of ORS 656.382(1). An attorney fee should be assessed.

In the Matter of the Compensation of
C. BERNICE CHANDLER, Claimant
WCB Case No. 89-26231
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of Referee Baker's order which: (1) denied its motion to dismiss claimant's request for hearing as untimely; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 23 percent (73.6 degrees), as awarded by a Determination Order, to 42 percent (134.4 degrees). In her brief, claimant contends that she is entitled to an additional unscheduled permanent disability award based upon an impairment value for an unoperated disc. On review, the issues are timeliness of hearing request and extent of unscheduled disability. We affirm in part and modify in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the following supplementation.

Claimant was 50 years old at the time of hearing. She has a high school diploma and one year of college. Claimant's highest SVP level in the ten years prior to hearing is 6 as a licensed practical nurse. DOT # 079.374-014. She has competence in a specific vocational pursuit.

Claimant was released to regular work but has had to modify her duties. The physical capacity necessary to perform her usual and customary work was heavy. Claimant returned to work requiring a physical capacity in the medium range.

Claimant retains 40 degrees extension in the cervical spine. She retains 55 degrees right rotation and 60 degrees left rotation.. She retains 25 degrees left lateral flexion and 15 degrees right lateral flexion.

Claimant retains 120 degrees abduction in her right shoulder and 35 degrees internal rotation.

Claimant retains 15 degrees extension in her thoracolumbar spine and 40 degrees flexion.

Claimant had a laminectomy with single discectomy and a fusion of L5-S1. She has chronic conditions limiting repetitive use of her right shoulder, neck, and low back.

Claimant has had continuing right leg problems since her fusion surgery.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

The Board adopts the Referee's "Opinion and Conclusions" with respect to this issue. See former OAR 438-05-046(1)(b).

Extent of Unscheduled Permanent Disability

Because claimant's condition became medically stationary on May 2, 1989, and her claim was closed by Determination Order on June 30, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq.

Age and Education

The appropriate value for claimant's age of 50 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's 13 years of formal education, including a high school diploma, is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was licensed practical nurse, SVP 6, (DOT # 079.374-014). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5). Claimant's total education value is 2.

Adaptability

The adaptability value for a claimant who has either returned to modified work or received a work offer [see former OAR 436-35-270(3)(d)] is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

Claimant was released to regular work, with the restriction by her physician that she do no heavy lifting, bending or twisting. (Ex. 124). Claimant testified that she has had to modify her duties herself by having fewer patients to attend to and by asking for help with lifting when necessary. We conclude that claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work requires a medium physical capacity. See former OAR 436-35-270(3)(b). Therefore, the appropriate adaptability value is 1. Former OAR 436-35-310(3)(a).

Impairment

The insurer argues that the Referee erred in awarding three separate awards for chronic conditions limiting repetitive use of separate body parts. We disagree. See Larry L. McDougal, supra.

Cervical Spine

Claimant retains 40 degrees extension in the cervical spine for a value of .33. She retains 55 degrees right rotation for a value of 1.25 and 60 degrees left rotation for a value of 1. She retains 25 degrees left lateral flexion for a value of 1.33 and 15 degrees of right lateral flexion for a value of 2. The total impairment value for loss of range of motion in the cervical spine is 5.9 percent. Former OAR 436-35-360(3),(4),(5)&(10).

Claimant also has a chronic condition limiting repetitive use of her cervical spine for a value of 5 percent. Combining the loss of range of motion and chronic condition limiting repetitive use, the total is 10.61 percent impairment of the cervical spine. Former 436-35-360(11).

Thoracolumbar Spine

Claimant retains 15 degrees extension in her thoracolumbar spine for a value of 1.5 percent and 40 degrees flexion for a value of 5. Claimant's total value for loss of range of motion in the thoracolumbar spine is 6.5. Former OAR 436-35-360(6),(7)&(10).

Claimant had a laminectomy with single discectomy for a value of 5 and a fusion of L5-S1 for a value of 5. Former OAR 436-35-350(2)&(3). Claimant also has a chronic condition limiting repetitive use of her thoracolumbar spine for a value of 5.

Claimant argues that she is entitled to an additional impairment value of 4 percent because she has a narrowing of the foramen at L5-S1 on the right side. That narrowing was noted in an MRI performed on January 16, 1988. Just prior to that MRI, on January 7, 1988, claimant saw her treating physician, Dr. Kendrick, with back pain and right leg pain occurring after a recent automobile accident. (Ex. 106). On January 7, Dr. Kendrick stated that claimant's most recent MRI (before the automobile accident) was stable and showed no evidence of nerve root compression. (Id.) The subsequent MRI showed the narrowing.

Dr. Kendrick offered no explanation as to the cause of the narrowing of the foramen. We are not able to conclude that the narrowing resulted from claimant's compensable injury, rather than her automobile accident. Further, because narrowing of the foreman does not imply disc derangement, we do not find that claimant is entitled to an additional impairment value of 4 percent.

Combining the loss of range of motion, chronic condition limiting repetitive use, and other spinal findings, the total is 19.84 percent impairment of the thoracolumbar spine. Former OAR 436-35-360(11).

Right Shoulder

Claimant retains 120 degrees abduction in her right shoulder for a value of 2 and 35 degrees internal rotation for a value of 0.5. Claimant's total loss of range of motion for her right shoulder is 2.5 percent. Former OAR 436-35-330(5)&(9).

Claimant also has a chronic condition limiting repetitive use of her right shoulder for a value of 5. Combining the loss of range of motion and chronic

condition limiting repetitive use, the total is 7.38 percent impairment of the right shoulder.

To find claimant's total impairment rating for multiple residuals, the ratings are combined. Combining the total impairments for claimant's cervical spine, thoracolumbar spine and right shoulder, we arrive at a total of 33.63 percent impairment.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to her education value, 2, the sum is 3. When that value is multiplied by claimant's adaptability value, 1, the product is 3. When that value is added to claimant's impairment value, 33.63, the result is 36.63 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the "standards" is, therefore, 37 percent.

We do not find clear and convincing evidence of greater or lesser permanent disability than is determined by application of the standards.

ORDER

The Referee's order dated June 19, 1990 is modified in part and affirmed in part. In lieu of the Referee's award and in addition to the Determination Order's award, claimant is awarded 14 percent (44.8 degrees) unscheduled permanent disability, for a total award to date of 37 percent (118.4 degrees) unscheduled permanent disability for her cervical and thoracolumbar spine conditions and her right shoulder condition. Claimant's attorney fee shall be adjusted accordingly. The remainder of the order is affirmed.

In the Matter of the Compensation of
ALFONSO S. GUTIERREZ, Claimant
WCB Case No. 90-06781
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Kinsley's order which affirmed a Determination Order that awarded no scheduled permanent disability for loss of use or function of claimant's right foot. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Because claimant's claim was closed by a Determination Order on October 25, 1989, the "standards" that were effective January 1, 1989 are applicable in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former

OAR 436-35-010 through 436-35-260 apply to the rating of claimant scheduled permanent disability. Former OAR 436-35-010(1).

Claimant argues that the Referee was in error to find persuasive reasons not to rely on the treating physician's opinion regarding claimant's right foot range of motion. We agree with the Referee that the findings of Drs. Tongue and Asper, which were made upon examination contemporaneous with the injury, are more persuasive than the opinion of Dr. Poul.

Further, we defer to the Referee's finding that claimant credibly testified that he experiences pain and discomfort in his right foot depending upon activity. We find this portion of claimant's testimony persuasive toward finding that claimant is limited in his ability to repetitively use his right foot. Claimant testified that he can not run as long as he used to be able. Currently, when he runs for a half an hour, his foot begins to hurt and he is forced to stop running to rest his foot. Additionally, claimant experiences pain going up and down stairs.

Accordingly, we conclude that claimant is entitled to an award of 5 percent for loss of repetitive use of his right foot. Former OAR 436-35-010(7). Claimant's total impairment under the standards is, therefore, 5 percent.

ORDER

The Referee's order dated June 25, 1990 is reversed. Claimant is awarded 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of his right foot. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, not to exceed $2,800.

April 15, 1991 Cite as 43 Van Natta 903 (1991)

In the Matter of the Compensation of
RICHELLE E. VOLZ, Claimant
WCB Case No. 90-00814
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Knapp's order that declined to award a carrier-paid attorney fee for prevailing against an alleged "de facto" partial denial of her right elbow condition. On review, the sole issue is attorney fees.

We affirm and adopt the order of the Referee, with the following modification concerning the attorney fee issue.

The SAIF Corporation accepted claimant's claim for right wrist tendonitis. (Ex. 17). At hearing, claimant raised the issue of an alleged "de facto" denial of a right elbow condition. The Referee found that the elbow condition was compensable, but that the SAIF Corporation's oral denial of that condition did not constitute a "de facto" denial.

Claimant reported symptoms, including pain and swelling, from the wrist to the elbow from the outset. (See Exs. 1, 4, 5, 9, 10). By September 1, 1989, Dr. Amsden suspected double crush or triple crush syndrome and prescribed

conservative treatment, including an elbow brace. (Ex. 10-1). On October 20, 1989, SAIF requested information from Amsden. Amsden responded that he suspected double crush syndrome and reported decreased nerve conduction velocity across claimant's right elbow. (Ex. 27). On November 29, 1989, Amsden prescribed a custom elbow brace for claimant's ulnar neuropathy. (Ex. 31).

Under former ORS 656.262, the insurer must accept or deny a claim within 60 days of notice or knowledge of the claim. The claim is deemed denied "de facto" after expiration of the 60-day period, if the insurer has not accepted or denied it. Barr v. EBI Companies, 88 Or App 132, 143 (1987). Based on the above evidence, we are persuaded that a claim was made for an elbow condition. See ORS 656.005(6). However, on this record, we are unable to determine when SAIF had notice or knowledge of that claim. Therefore, we conclude that claimant has not established that there was a "de facto" denial.

SAIF did, however, expressly deny claimant's elbow condition on the record at hearing (Tr. 2-3, 17). The Referee found the elbow condition to be compensable. Claimant is entitled to a reasonable assessed attorney fee for prevailing on the denied claim. ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing, regarding the elbow condition, is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the benefit secured for claimant.

ORDER

The Referee's order dated June 27, 1990 is modified in part. Claimant's attorney is awarded a reasonable assessed fee of $1,000, for his services at hearing regarding compensability of the elbow condition, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CLEOPHAS C. CHAMBLISS, Claimant
WCB Case No. 89-24362
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorney

Reviewed by Board Members Nichols, Crider and Brittingham.

Claimant requests review of those portions of Referee Danner's order that: (1) declined to set aside the Determination Order issued on November 24, 1989 as premature; (2) amended claimant's medically stationary date from September 25, 1989 to March 29, 1989; (3) authorized the self-insured employer to recover temporary disability paid after March 29, 1989 against claimant's future awards of permanent disability; (4) declined to assess penalties and attorney fees for an allegedly unreasonable denial of chiropractic care issued on March 21, 1990; (5) upheld the self-insured employer's denial of chiropractic care, as clarified by the March 21, 1990 letter; and (6) declined to grant claimant an increased award of unscheduled permanent disability for a back and neck condition beyond the 12 percent (38.4 degrees) awarded by Determination Order. On review, the issues are premature closure, medically stationary date, offset, medical services, penalties and attorney fees, and alternatively, extent of unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the ultimate finding that finds claimant medically stationary on March 29, 1989. We instead find that claimant last became medically stationary on September 25, 1989.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt that portion of the order that addresses the issues of the denials of chiropractic care, and penalties and attorney fees.

Premature Closure/Medically Stationary Date

The Referee found that the overwhelming weight of the evidence supported a finding that claimant became medically stationary in March 1989 when she was examined by the Orthopaedic Consultants. Claimant argues that she was not yet medically stationary at the time of the hearing. We disagree with both claimant and the Referee.

A claim is properly closed when the claimant becomes medically stationary. Former ORS 656.268(2). "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to prove that the claim was closed prematurely.

Propriety of closure must be evaluated in light of claimant's condition at the time of closure and not of subsequent developments. Post-closure evidence may be considered insofar as it is relevant to whether claimant's condition at the time of closure was likely to improve with time or treatment. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

Claimant returned to work after she was examined by the Orthopaedic Consultants in March 1989. Because of an increase in symptoms and discomfort, she was again taken off work by her treating chiropractor the summer of 1989. She was released to and did return to the job she was doing in early summer of 1989 on a part time basis. Claimant continued receiving treatments and had some improvement in her pain complaints prior to being examined by Dr. Howell in September 1989.

When there is a conflict of medical opinions, as is the case here, we rely on those opinions which are well reasoned and based upon complete information. Somers v. SAIF, 77 Or App 215 (1986). Claimant's treating chiropractor, Dr. Krupa, has consistently reported that claimant will be medically stationary in a couple of months. His reports, however, do not document changes in claimant's condition which would reflect material improvement after Dr. Howell's examination. We do not find Dr. Krupa persuasive. Instead, we conclude that Dr. Howell's consulting medical examination is more persuasive. Dr. Howell's report is much more extensive, is based on a review of the medical file and is more reasoned than is Dr. Krupa's. Finding Dr. Howell to be persuasive, we are convinced that claimant was medically stationary when she was examined by Dr. Howell in September 1989.

Accordingly, the Referee correctly concluded that the claim was not prematurely closed by the November 24, 1989 Determination Order. However, we reinstate the Determination Order medically stationary date of September 25, 1989. In light of this reasoning, the Referee's authorization to the employer to offset temporary disability paid after March 29, 1989 is reversed.

Extent of Disability

The Referee affirmed the award of 12 percent unscheduled permanent disability that was made in the Determination Order that was issued on November 24, 1989. Claimant argues that the value given by the Evaluation Section for adaptability and impairment were incorrect and should be increased. Claimant concedes the other values for age (0) and education (2) are correct. We write to address only those values that claimant contests.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

Because claimant's condition became medically stationary on September 25, 1989, and her claim was closed by Determination Order on November 24, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq.

Adaptability

The Evaluation Section awarded a +2 adaptability value. Claimant contends that her adaptability factor should be a +6 because she is restricted to light/sedentary lifting and she is not working. We disagree. Claimant was released to modified part time work by her attending chiropractor in July 1989 and did in fact return to part time work. She worked at that job until the job ran out. Claimant was not working at the time of the hearing because the job ended, not as a result of her compensable injury. Therefore, we conclude that claimant's adaptability is properly determined under former OAR 436-35-310(3)(a); Joyce M. Ramirez-Jones, 43 Van Natta 342 (1991). We disavow our decisions in Barbara L. Partridge, 42 Van Natta 1193 (1990), and Robin M. Glover, 42 Van Natta 1081 (1990), to the extent they are inconsistent with our ruling in this case.

The adaptability value for a claimant who has either returned to modified work or received a work offer [see former OAR 436-35-270(3)(d)] is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium work. Claimant's modified work required a light/sedentary physical capacity. Therefore, the appropriate adaptability value is +2.5. Former OAR 436-35-310(3)(a).

Impairment

The Evaluation Section awarded a total impairment value of 8 percent, for loss of lumbar range of motion. Claimant agrees that the correct value for loss of range of motion of the lumbar spine is 8 percent. She contends, however, that she should have received a value for loss of range of motion of the cervical spine and for loss of repetitive use.

Dr. Howell, as well as the Orthopedic Consultants, did report some loss of range of motion of claimant's cervical spine. When claimant was first examined by the Orthopaedic Consultants in July 1988, less than 3 months after her injury, a cervical, dorsal and lumbar strain was diagnosed and some loss of motions were reported. We agree with claimant that her cervical spine was also part of this accepted claim. Using Dr. Howell's report, we find that claimant has normal flexion, extension, and left lateral bending, has 30 degrees of right lateral bending, 40 degrees of left rotation and 45 degrees of right rotation for a loss of cervical range of motion of 5 percent. Former OAR 436-35-360. Claimant further contends she is entitled to 5 percent under former OAR 436-35-320(4) for chronic conditions limiting repetitive use of an unscheduled body part. Claimant's brief is not clear as to whether this loss of repetitive use is due to the cervical spine, the lumbar spine or both. However, we do not find that claimant has such limitation. The only medical evidence that so limits claimant is that of Dr. Krupa, whom we have found not to be persuasive. We decline to rely on his reports to find such limits when neither Dr. Howell nor the Orthopaedic Consultants make such findings. We combine the values for the lumbar and cervical areas to reach a total impairment rating of 12.6 percent.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 2, the sum is 2. When that value is multiplied by claimant's adaptability value 2.5, the product is 5. When that value is added to claimant's impairment value 12.6, the result is 17.6 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 18 percent.

ORDER

The Referee's order dated May 8, 1990 is affirmed in part and reversed in part. Those portions of the order that found claimant medically stationary on March 29, 1989 and that affirmed the Determination Order award of permanent disability are reversed. That portion of the Determination Order that found claimant to be medically stationary on September 25, 1989 is reinstated. That portion of the Referee's order that granted the insurer an offset of temporary disability paid after March 29, 1989 against future permanent disability awards is reversed. Claimant is granted an award of 6 percent (19.2 degrees) unscheduled permanent disability in addition to the 12 percent (38.4 degrees) granted by the Determination Order for a total award of 18 percent (57.6 degrees) unscheduled permanent disability for her neck and back conditions. Claimant's attorney is entitled to 25 percent of the increased compensation granted by this order, as and for attorney fees not to exceed $3,800, payable directly to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
JAMES S. ESPINOZA, Claimant
WCB Case No. 89-21372
ORDER ON REVIEW
Dennis W. Skarstad, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

The SAIF Corporation requests review of those portions of Referee Crumme's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) assessed a 10 percent penalty and related attorney fee for its allegedly unreasonable failure to timely accept or deny claimant's "new injury" claim for the same condition; (3) assessed a 10 percent penalty and related attorney fee for its allegedly unreasonable failure to pay interim compensation due for the "new injury;" (4) assessed a 10 percent penalty and related attorney fee for its allegedly unreasonable four-day delay in paying an earlier award of permanent partial disability; and (5) assessed a 25 percent penalty and related attorney fee for its allegedly unreasonable failure to provide discovery of evidence. Claimant cross-requests review of that portion of the order that: (1) upheld SAIF's "de facto" denial of claimant's "new injury" claim for the same condition; (2) declined to award interim compensation beginning June 8, 1989; and (3) assessed penalties based on unpaid compensation from June 8, 1989 through February 22, 1990. On review, the issues are compensability, interim compensation and penalties and attorney fees. We affirm in part, reverse in part and modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee, applying Weller v. Union Carbide, 288 Or 27 (1979), found that claimant had not sustained a new injury on June 8, 1989, because claimant had not established that his underlying condition was worsened by the work activity. The Weller test, however, is the standard of proof relating to a claim for an occupational disease. It does not apply to an industrial injury claim. Barrett v. D & H Drywall, 300 Or 325 (1985).

Nonetheless, while the Weller test is inapplicable to claimant's injury claim, the determination of whether a claimant suffered a "new injury" or an "aggravation" involves a similar analysis. In Teresa L. Walker, 41 Van Natta 2283 (1989), we held that, in cases involving a single employer/insurer, worsened symptoms of a compensable injury represent an aggravation, assuming all other requirements of an aggravation claim are met. We further held that a worker suffers a "new injury" only if the subsequent work activity independently contributes to a worsening of the underlying condition. See also Cipriano Vage, 42 Van Natta 1117 (1990).

Whether claimant's work activity on June 8, 1989 caused a worsening of his underlying condition is a complex medical question. Thus, while claimant's testimony is probative, the resolution of the issue largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

As noted by the Referee, the only medical evidence on the question comes from Dr. Butler, claimant's treating physician. Dr. Butler's chart notes of June 9, 1989 expressed the general belief that claimant had sustained a new injury. (Ex. 4-2). However, Dr. Butler later expressed the opinion that

claimant's condition had not objectively worsened and that he believed that claimant was merely experiencing a waxing and waning of his previous injury. (Ex. 11). Because of the inconsistencies in Dr. Butler's opinion, we do not find it persuasive and, accordingly, give it little weight. See David H. Olson Jr., 42 Van Natta 1336 (1990).

After our de novo review of the record, we find that claimant has not established that his underlying condition was independently worsened by the June 8, 1989 work activity and, therefore, conclude that he did not sustain a "new injury." We now proceed to determine whether claimant sustained a compensable aggravation.

To prove a compensable aggravation, claimant must show: (1) increased symptoms or a worsened underlying condition; and (2) a resultant diminished earning capacity since the last arrangement of compensation. In those cases in which the last award of compensation anticipated future exacerbations of the worker's symptoms, a claimant must also show that the degree or duration of his reduced earning capacity is greater than that anticipated by the last arrangement of compensation. Gwynn v. SAIF, 304 Or 345 (1987); Edward D. Lucas, 41 Van Natta 2272 (1989). If it cannot be determined what the last award contemplated, then the inquiry becomes whether the claimant experienced 14 consecutive days of total disability or inpatient hospitalization. Gwynn v. SAIF, supra; International Paper Co. v. Turner, 84 Or App 248 (1987), on remand, 91 Or App 91, 94 (1989).

Turning to the facts of this case, it is undisputed that claimant experienced a symptomatic worsening of his condition and that, as a result of the worsening, he suffered a diminished earning capacity. It is unclear, however, whether the degree or duration of his reduced earning capacity was greater than what was anticipated by the February 15, 1989 Opinion and Order, the last award of compensation. SAIF relies on a report by the Western Medical Consultants, who examined claimant in August 1989. They concluded:

> "It appears based on objective findings, that [claimant's] condition is unchanged from spring and mid-summer of 1987. It is our opinion that his present symptoms are those that would be expected to wax and wane in a person with 20 percent disability to the low back, and in fact, the continuing symptoms are most probably the principle reason that a 20 percent disability was awarded." (Ex. 8-4).

However, the record reveals that, in the February 15, 1989 Opinion and Order, the Referee increased claimant's award of permanent partial disability from 10 to 20 percent, simply because the parties agreed that the evaluator had incorrectly assumed that claimant had returned to his regular work.

After our review of the record, we are unable to determine what duration or degree of reduced earning capacity was anticipated by the last award of compensation. Nonetheless, we agree with the Referee that claimant experienced 14 consecutive days of total disability. In a letter dated June 19, 1989, Dr. Butler advised SAIF that claimant had been unable to work since June 9, 1989, and that he was unable to determine when claimant would be able to return. (Ex. 6). Later, on July 24, 1989, Dr. Butler noted that claimant had not worked in six weeks. (Ex. 3-3). On that date, he released claimant to modified work. Inasmuch as there is no evidence contradicting claimant's total disability of at least 14 consecutive days, we conclude that claimant sustained a compensable aggravation of his low back condition.

Interim Compensation

The Referee concluded that claimant was entitled to interim compensation for the period between June 15, 1989 and February 22, 1990. We modify.

For a new injury claim, a claimant is entitled to interim compensation for the period between the date the insurer receives notice of the claim and the date of its formal denial. ORS 656.262(2). If an insurer does not formally deny the claim, interim compensation is due through the date of hearing. Valerie D. Barry, 41 Van Natta 199 (1989).

In this case, claimant testified at hearing that he gave his supervisor a completed 801 form on approximately June 15, 1989, at his employer's request. Based on claimant's demeanor, the Referee found that testimony credible and concluded that the employer had knowledge of the claim on June 15, 1989. However, after a review of the evidence, we find that the employer was made immediately aware that claimant had sustained a work-related injury on June 8, 1989, and was also aware that claimant did not return to work for a period of time thereafter. (Tr. 39). We find that those facts were sufficient to lead a reasonable employer to conclude that worker's compensation liability was a possibility and that further investigation was appropriate. See Melton J. Jackson, 42 Van Natta 264 (1990). Therefore, we conclude that the duty to pay interim compensation was triggered on June 8, 1989. Furthermore, because SAIF never formally denied the claim, interim compensation is due through February 22, 1990, the date of hearing. Valerie D. Barry, supra.

Penalties and Attorney Fees - Claimant's "New Injury" Claim

The Referee assessed a total of three penalties and related attorney fees for SAIF's allegedly unreasonable processing of claimant's "new injury" claim. First, he assessed a 10 percent penalty and related attorney fee for SAIF's failure to accept or deny the new injury claim within 60 days after it had received notice of the claim. See ORS 656.262(6). Second, he imposed a 10 percent penalty and related attorney fee for SAIF's failure to pay claimant interim compensation within 14 days after it had received notice of the claim. ORS 656.262(4). Third, the Referee imposed a 25 percent penalty and related attorney fee for SAIF's failure to respond to claimant's July 6, 1989 request for discovery.

After our de novo review of the record, we agree with the Referee with regard to the first and second penalties and related attorney fees. See Valerie D. Barry, supra at 206. Accordingly, we adopt the conclusions and reasoning concerning those issues as set forth in the Referee's order. We do not agree, however, with the third penalty and attorney fee.

Subsequent to the Referee's order, the Board issued Buck E. Johnson, 43 Van Natta 423 (1991). In that case, we held that a carrier's failure to provide exhibits as required by administrative rules did not warrant the assessment of a penalty and attorney fee because there had been no unreasonable resistance to the payment of compensation. We reasoned that, absent a showing that the insurer's inaction affected some obligation to pay compensation due in the past, present or future, it cannot be said that there was any resistance to such payment. Id. at 427.

We conclude that the same reasoning applies here. The Referee assessed a penalty and attorney fee based on SAIF's failure to reasonably comply with claimant's discovery request as required by OAR 436-10-030. While SAIF's failure to timely respond may have been unreasonable, its conduct did not result in an unreasonable delay or refusal to pay compensation. See ORS 656.262(10);

ORS 656.382(1). Accordingly, the Referee's assessed penalty is reversed; the Referee's combined $3,338 attorney fee award is reduced accordingly.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services concerning the aggravation denial and SAIF's unreasonable failures to accept or deny the "new injury" claim or to pay interim compensation is $2,800, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record), the complexity of the issues, and the value of the interest involved.

Penalty and Attorney Fee - Failure to Pay Permanent Partial Disability.

The Referee also assessed a penalty and related attorney fee for SAIF's late payment of the permanent disability awarded by an earlier opinion and order. After our review of the record, we agree with the Referee that SAIF's actions were unreasonable and that a 10 percent penalty is appropriate under the circumstances. Accordingly, we adopt the conclusions and reasoning concerning that issue as set for in the Referee's order.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $400 is a reasonable assessed fee for claimant's counsel's efforts on review concerning the issue of aggravation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue presented, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for defending on the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Finally, he is not entitled to a fee for his unsuccessful attempt to overturn the Referee's order concerning the "new injury" claim.

ORDER

The Referee's order dated April 30, 1990 is affirmed in part, reversed in part and modified. The Referee's award is modified to reflect an award of interim compensation from June 8, 1989 to February 22, 1990. That portion of the Referee's order that assessed a 25 percent penalty and related attorney fee for SAIF's allegedly unreasonable failure to respond to claimant's request for discovery is reversed. In lieu of the Referee's total attorney fee award, claimant's counsel is awarded a total attorney fee of $2,800, payable by the SAIF Corporation for services at hearing. For services on Board review concerning the aggravation issue, claimant's attorney is also awarded a reasonable fee of $400, to be paid by SAIF. The remainder of the order is affirmed.

April 16, 1991 Cite as 43 Van Natta 911 (1991)

In the Matter of the Compensation of
NANCY L. LUCAS, Claimant
WCB Case No. 89-04465
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Crumme's order which: (1) set aside its denial of claimant's aggravation claim for an irritable bowel syndrome; and (2) set aside its partial denial of a stress claim. On review,

the issues are aggravation and compensability. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the following supplementation.

Based on information gained at the deposition of Dr. Klecan, claimant filed an occupational disease claim for stress. (Tr. 22, 34).

CONCLUSIONS OF LAW AND OPINION

Aggravation of the Irritable Bowel Syndrome

The Board adopts the Referee's "Conclusions of Law" with respect to the issue of aggravation of claimant's irritable bowel syndrome, with the following comments.

The temporary or permanent nature of a compensable injury or occupational disease cannot be determined until claimant is medically stationary and the claim is closed. See ORS 656.268; Roller v. Weyerhaeuser Co., 67 Or App 583 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). Accordingly, we are not persuaded by SAIF's argument that because it accepted "temporary irritable bowel syndrome" claimant cannot claim an aggravation of the condition. Also, the fact that there was no award of permanent disability does not preclude an aggravation claim. See Graham v. Schnitzer Steel Products, 82 Or App 162 (1986); Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Compensability of a Stress Claim

SAIF argues that the Board should uphold its October 16, 1989 denial of claimant's occupational disease claim for stress. We agree.

As a result of information claimant learned at the deposition of Dr. Klecan concerning the fact that irritable bowel syndrome symptoms generally develop in response to emotional distress, claimant filed an occupational disease claim, contending that the irritable bowel syndrome arose as a consequence of a stress induced disease. (Tr. 22, Ex. 23-13-15). SAIF does not assert claim preclusion as a defense.

SAIF does argue that claimant is barred by issue preclusion. However, because the issue was not raised or litigated at a prior hearing on November 27, 1988, issue preclusion does not apply. See Drews v. EBI Co., 310 Or 134 (1990).

To be compensable, claimant's occupational disease must fall within one of the three subsections of former ORS 656.802. It appears that claimant is asserting an occupational disease in the form of a mental disorder. Consequently, we analyze this claim under that section of the statute. Pursuant to former 656.802(1)(b) and (2), to establish a compensable mental disorder, claimant must establish that: (1) she has a diagnosed mental or emotional disorder which is generally recognized in the medical or psychological community; (2) the mental disorder required medical services or resulted in disability; (3) the mental disorder was due to employment conditions which were real and objective; and (4) such employment conditions are not generally inherent in every working environment or reasonable disciplinary, corrective or job performance evaluation actions. The evidence must be clear and convincing that the mental disorder arose out of and in the course of employment.

The Board has previously held that "stress" in and of itself, is not a condition which is generally recognized as a "mental disorder." See Ronald V. Dickson, 42 Van Natta 1102 (1990); Sharon Schettler, 42 Van Natta 2540 (1990). Claimant has offered no evidence to the contrary in this case. Several doctors have referred to claimant's "depression" however none have diagnosed her as having a depressive disorder. Dr. Burns, psychologist, stated that "while her depression was not quite at clinical levels, on the MMPI it was very close to being clinical [sic] significant. (Ex. 21-3). Dr. Farley, M.D., who saw claimant while she was hospitalized, stated that claimant did have some symptoms of depression, but without a major depressive syndrome. (Ex. 18A-6). Dr. Turco stated that claimant did not have any psychiatric diagnosis.

After reviewing the psychiatric and psychological evidence, we conclude that claimant has failed to prove that she suffers from a diagnosed mental or emotional disorder which is generally recognized in the medical or psychological community. Claimant's mental condition, apart from her compensable irritable bowel syndrome and its consequences, did not require medical treatment or result in disability. Accordingly, we need not address the remaining elements required to establish a stress-related occupational disease in concluding that claimant's stress claim is not compensable.

At hearing, the Referee awarded claimant an attorney fee for prevailing on both the issue of aggravation and occupational disease for a mental condition. On Board review, we have reversed the Referee's order in part, resulting in claimant prevailing only on the aggravation issue. Accordingly, we adjust Referee's attorney fee award.

For services at hearing, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services for prevailing on the issue of aggravation is $2,000, to be paid by SAIF.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on Board review concerning the issue of aggravation of her irritable bowel syndrome is $800, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated June 11, 1990 is affirmed in part, modified in part, and reversed in part. That portion which set aside the SAIF Corporation's partial denial of claimant's occupational disease claim for stress is reversed. SAIF's denial is reinstated and upheld. That portion which set aside claimant's aggravation claims is affirmed. In lieu of the Referee's assessed attorney fee award, claimant is awarded a reasonable assessed attorney fee for services at hearing concerning the aggravation issue of $2,000, payable by SAIF. For services on Board review concerning the aggravation issue, claimant's attorney is awarded a reasonable assessed attorney fee of $800, payable by the SAIF Corporation.

In the Matter of the Compensation of
JOHNNY C. MADISON, SR., Claimant
WCB Case Nos. 90-01370 & 89-25850
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Darrell E. Bewley, Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Liberty Northwest Insurance Co., on behalf of Execulodge, requests review of Referee Bethlahmy's order that: (1) set aside its denial of an aggravation claim for a back condition; and (2) upheld Liberty Northwest's denial, on behalf of Hall Laboratories, of a "new injury" claim for the same condition. Liberty Northwest, on behalf of Hall Laboratories, cross-requests review of the Referee's rulings excluding Exhibits 23, 24, 25, and B. On review, the issues are evidence and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and make the following additional findings.

Claimant's 1988 compensable injury with Execulodge was a material contributing cause of his November 1989 exacerbation. As a consequence of the exacerbation, claimant was less able to work.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion."

On review, Execulodge concedes that claimant has established a compensable worsening of his condition, but contends that work at Hall Laboratories caused a worsening of the underlying condition and hence justifies a shift in responsibility to Hall. We disagree.

Execulodge relies on a portion of Dr. Milner's April 2, 1990 report that states that, "It is unquestionable that the injury on 10/30/89 has hastened and aggravated Mr. Madison's pre-existing disk bulging which has symptoms and pathology requiring additional treatment as well as time lost from work." In view of Dr. Milner's other reports, we are not persuaded that Dr. Milner intended to say that claimant's underlying condition was worsened. In his first report following the November 1989 exacerbation, Dr. Milner stated that claimant had suffered an exacerbation. His subsequent reports noted an increase in pain and disability but no new pathology. These reports are consistent with those of the Western Medical Consultants and the Orthopaedic Consultants. On the record as a whole, we are persuaded that claimant's underlying condition did not worsen as a result of the claimant's work for Hall Laboratories. Therefore, we affirm on the responsibility issue.

As to the evidentiary issues, we agree with the Referee that Exhibits 23, 24 and 25 are irrelevant. They discuss a discovery dispute which was not before the Referee. Hall suggests that they are relevant because they tend to shed light on the meaning of Exhibit 18a. Hall suggests that because there was a delay in producing the exhibit, the Referee should infer that the exhibit undermines Execulodge's position. We disagree. The exhibit is in the record and speaks for itself. This is not a situation in which an inference may be drawn from a party's failure to produce evidence.

Hall also suggests that the Referee erred in declining to admit Exbibit B, a termination form. The form was offered to prove that claimant had stated to a supervisor that he was quitting due to dust in the workplace. (Tr. 29). The Referee correctly concluded that the fact that claimant's signature appeared on the form did not cure the hearsay nature of the contents. She did not err in excluding it. Even if the Referee had erred in excluding the form, the error would be harmless. Claimant has not contended and we have not found that he left Hall due to the exacerbation of his compensable condition.

Claimant is entitled to an attorney fee for services on review, payable by Liberty NW/Execulodge. ORS 656.382(2), Tonya L. Baker, 42 Van Natta 2818 (1990). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning Liberty Northwests denial is $100, to be paid by Execulodge. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by claimant's respondent's brief).

ORDER

The Referee's order dated July 27, 1990 is affirmed. For services on review, claimant's attorney is awarded a $100 assessed fee, payable by Liberty Northwest on behalf of Execulodge.

In the Matter of the Compensation of
CHRIS A. MINER, Claimant
WCB Case Nos. 90-01112 & 89-22276
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Seifert's order which declined to award claimant's counsel an assessed attorney fee for his counsel's efforts regarding the insurer's denial of medical services. On review, the sole issue is attorney fees. We reverse.

FINDINGS OF FACT

Claimant's claim originally involved two employers and responsibility and compensability were the issues before the Hearings Division. One employer was dismissed as a party and the issue against the remaining employer was compensability. The insurer rescinded its denial on March 5, 1990. However, the issue of claimant's attorney fees remained. On March 15, 1990, the insurer wrote in closing argument that, "The only issue is the amount of attorney fee for [claimant's counsel]."

On April 3, 1990, the Referee signed a Stipulation and Order whereby the parties agreed that the insurer rescinded its denial of medical services. Further, the parties stipulated that, "It is contemplated by the parties that Referee Seifert will be issuing an Opinion and Order concerning the payment of claimant's attorney's fees."

On April 20, 1990, the Referee determined that claimant was entitled to a reasonable assessed attorney fee in the amount of $1,500 pursuant to OAR 438-15-010(6)(g).

Duane L. Jones, 42 Van Natta 875 (1990), issued on April 17, 1990, and the insurer requested reconsideration.

CONCLUSIONS OF LAW AND OPINION

In his "Order on Reconsideration," relying on Duane L. Jones, supra, the Referee denied claimant's "claim for an assessed attorney fee."

We read the insurer's statement in its closing argument, "The only issue is the amount of attorney fee ...," together with the wording in the Stipulation, "It is contemplated by the parties that Referee Seifert will be issuing an Opinion and Order concerning the payment of claimant's attorney's fees" and conclude that the parties had an agreement that claimant was entitled to an attorney fee, the amount of which was to be set by the Referee. Whether or not claimant would have been entitled to an award under the pertinent law for his work prior to the Stipulation, the insurer agreed that claimant was entitled to an such an award. It is not for the Referee or the Board to question the parties' agreement. Evans v. Rookard, Inc., 85 Or App 213 (1987); also see Charles T. Brence, 41 Van Natta 1429 (1989).

In his initial order, the Referee set the amount of the attorney fee at $1,500. After considering the factors set forth in OAR 438-15-010(4), we conclude that the amount of the Referee's award is reasonable.

Accordingly, we reverse the Referee's Order on Reconsideration and affirm the Opinion and Order setting the amount of attorney fees at $1,500.

ORDER

The Referee's Order on Reconsideration dated June 4, 1990 is reversed. The Referee's order dated April 20, 1990 is affirmed.

April 16, 1991 Cite as 43 Van Natta 916 (1991)

In the Matter of the Compensation of
RUSSELL PIPER, Claimant
WCB Case No. 90-03200
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Janice Pilkenton, Defense Attorney

Reviewed by Board Members Westerband and Myers.

The insurer requests review of that portion of Referee Lipton's order that awarded claimant an assessed fee for services at hearing. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as our own.

CONCLUSIONS OF LAW AND OPINION

Attorney Fee

The Referee awarded claimant an assessed fee for services at hearing "for prevailing in the contest concerning the bruise." We disagree.

At the time of hearing, the sole issue was the extent of claimant's scheduled permanent disability resulting from his thrombophlebitis claim. At

hearing, questions arose regarding an alleged "de facto" denial of claimant's bruise and whether claimant's ongoing leg pain was a result of the thrombophlebitis. Claimant argued that his current leg pain was caused by the bruise, that the pain was chronic, and that the chronic pain entitled him to an award of scheduled permanent disability.

The insurer argued and the Referee found that the compensability of claimant's bruise was previously litigated as part of his thrombophlebitis claim. Thus, the issue of the compensability of claimant's bruise was not properly before the Referee. However, the Referee awarded claimant's attorney an assessed fee regarding the compensability of the bruise.

The insurer argues that claimant did not finally prevail in a hearing before a Referee on a denied claim and that claimant was not entitled to an assessed fee. We agree.

ORS 656.386(1) provides for an assessed fee only where claimant finally prevails in a hearing before the Referee. See ORS 656.386(1); Duane L. Jones, 42 Van Natta 875 (1990); Randolph T. Sloan, 42 Van Natta 1309 (1990); Ernest C. Richter, 42 Van Natta 955 (1990). Here, there was no "de facto" denial of claimant's bruise. In fact, the bruise is an accepted component of claimant's thrombophlebitis claim which was finally litigated and found compensable. Because that issue was not properly before the Referee, we find that claimant did not finally prevail in a hearing on a denied claim regarding the bruise. Consequently, we conclude that claimant's attorney is not entitled to an assessed fee for services pertaining to that issue.

ORDER

The Referee's order dated August 3, 1990 is reversed in part. The Referee's attorney fee award of $1,200 for services pertaining to the compensability of claimant's bruise is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
HELEN M. WILSON, Claimant
WCB Case No. 89-24371
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Neal's order that upheld the self-insured employer's denial of her neck injury claim on the ground that it was not timely filed. On review, the issue is timeliness of filing of the claim. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On review, claimant first contends that the Referee erred in concluding that her claim was properly analyzed as an industrial injury claim rather than an occupational disease claim. We disagree.

An accidental injury is generally unexpected and sudden in onset. An occupational disease, on the other hand, develops gradually over a period of time and cannot be said to be an unanticipated result of a worker's continuous exposure to conditions in particular kinds of employment. James v. SAIF, 290 Or 343 (1981).

After our de novo review of the record, we conclude that claimant's condition was the result of an injury that occurred in December 1988, rather than an occupational disease. On the claim form, claimant stated that she was pulling wood off the round table when she experienced "a sharp pain" in her neck. (Ex. 2). Thereafter, claimant consistently referred to a discrete identifiable event in December 1988 that caused a sudden onset of pain. Contrary to claimant's suggestion, the fact that the pain continued for several months does not necessarily make it "gradual in onset" and therefore the result of an occupational disease. See Donald Drake Co. v. Lundmark, 63 Or App 261 (1983). Accordingly, claimant's claim is properly characterized as one for an industrial injury.

Claimant next contends that the Referee erred when she upheld the employer's denial on the ground that timely notice of the accident had not been given. Citing Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984), claimant argues that the employer waived the timeliness defense by failing to raise it within 14 days after the filing of the claim.

We rejected that argument in James E. Marek, 42 Van Natta 2578 (1990). Van Horn speaks to a carrier who seeks to avoid a penalty for failure to timely commence payment of compensation while also avoiding waiver of the timeliness defense by payment of compensation. Under those circumstances, the defense must be raised by a denial of the claim within 14 days of filing. The defense is not waived, however, by the failure to deny the claim with 14 days where the carrier simply decides not to commence payment of compensation. As we explained in James E. Marek, supra, a carrier choosing that course of action risks only the assessment of a penalty and related attorney fee. Therefore, the employer timely raised the defense.

Claimant last contends that the Referee erred in concluding that her injury claim was barred by her failure to give notice as required by ORS 656.265. We disagree and adopt the conclusions and reasoning concerning that issue as set forth in the Referee's order.

ORDER

The Referee's order dated May 30, 1990 is affirmed.

In the Matter of the Compensation of
DAVID G. PAYNE, Claimant
WCB Case No. TP-90063
THIRD PARTY DISTRIBUTION ORDER
Lauren Paulson, Claimant Attorney
Stoel, et al., Defense Attorneys

Tectronix, a paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to whether Tectronix's lien includes claim costs attributable to an independent medical examination. We conclude that these costs are not reimbursable and a

distribution in which Tectronix receives $1,354.90 from the $5,362.90 settlement is "just and proper."

FINDINGS OF FACT

In June 1989, claimant was injured while performing his work activities when the vehicle he was operating collided with a vehicle driven by a third party. Claimant did not miss time from work, but has received medical treatment. Tectronix has accepted the claim.

Shortly after the accident, Tectronix advised claimant of his rights to either seek damages from the third party on his own behalf or to assign his claim to them. In July 1989, claimant's counsel notified Tectronix that claimant had decided to pursue the third party claim on his own behalf.

Tectronix scheduled an independent medical examination (IME) for January 23, 1990. Claimant did not attend this examination. Thereafter, the IME was rescheduled for February 21, 1990. Tectronix was billed $632 for the report resulting from this examination, as well as $297.50 for the rescheduled January 1990 exam. Both of these bills were paid by Tectronix.

A July 1990 Determination Order closed claimant's claim. No temporary or permanent disability was awarded. Shortly thereafter, Tectronix provided claimant's counsel with an update of its total lien. Counsel was advised that $2,284.40 in medical expenses had been incurred.

On November 7, 1990, without Tectronix's approval, claimant's counsel and the third party insurer settled claimant's action for $5,362.90. In forwarding its check to claimant's counsel, the third party insurer understood that claimant's counsel "would reimburse the workers' compensation carrier for their lien in the amount of $1,362.90."

On November 12, 1990, Tectronix reminded claimant's counsel of its lien and requested an update of further developments. On November 12 and December 4, claimant's counsel responded. Notifying Tectronix of the settlement, claimant's counsel submitted to Tectronix a check in the amount of $1,022.18 as its share of the proceeds. In the event Tectronix demanded a further share, claimant's counsel suggested arbitration with the third party insurer.

Claimant's counsel distributed the $5,362.90 settlement proceeds in the following manner:

Attorney fee	$1,170.36
Litigation Expenses	10.00
Tectronix's Claim Cost Reimbursement	1,022.18
Remaining Balance to Claimant	3,160.36

On December 7, 1990, Tectronix returned the $1,022.18 check to claimant's counsel. Demanding $2,284.40 as its full share of the settlement proceeds, Tectronix sought Board resolution of the dispute.

In February 1991, Tectronix approved the $5,362.90 third party settlement. However, it continues to seek full reimbursement of its $2,284.40 claimed lien. A portion of Tectronix's lien ($929.50) pertains to costs incurred in obtaining the IME. $632 of these costs resulted from the February 21, 1990 examination and subsequent report. The remaining $297.50 was incurred as a result of the rescheduled January 23, 1990 examination.

The $929.50 in medical bills for the rescheduled January 1990 IME and the February 1990 IME/report were incurred for claim evaluation purposes. These

bills were not incurred as expenditures for compensation, first aid or other medical, surgical or hospital service. A distribution of the third party settlement proceeds in which Tectronix receives $1,354.90 would be "just and proper".

CONCLUSIONS OF LAW

If the worker settles a third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds, "an amount which is just and proper", provided that the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). Such an approach is taken to avoid making "equitable distributions on an ad hoc basis" and to permit the parties to generally know where they stand as they seek to settle a third party action. Marvin Thornton, 34 Van Natta 999, 1002 (1982). We find no persuasive reason to depart from that approach here.

Pursuant to ORS 656.593(1)(a), attorney fees and costs incurred shall be initially disbursed. Then the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. ORS 656.593(1)(c). Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278. Id. Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Claim evaluation reports are analogous to litigation reports and, as such, not properly includable in a paying agency's lien against a third party recovery. Cleo Riggs, 42 Van Natta 377 (1990); Carolyn J. Gant, 39 Van Natta 471 (1987); Darrell L. Rambeau, 38 Van Natta 144 (1986); Shawn Cutsforth, 35 Van Natta 515, 517 (1983).

In accordance with the Riggs rationale, Tectronix acknowledges that independent medical examinations are not reimbursable as "expenditures for compensation, first aid or other medical, surgical or hospital service" under ORS 656.593(1)(c). However, Tectronix argues that such expenditures are reimbursable as "other costs of the worker's claim under ORS 656.001 to 656.794." See ORS 656.593(1)(c).

We disagree with Tectronix's contention. To begin, the holdings of the aforementioned Board decisions support the proposition that claim evaluation reports are not reimbursable from a third party recovery, regardless of what phrase in ORS 656.593(1)(c) is applied. Moreover, since the phrase "other costs of the worker's claim under ORS 656.001 to 656.794" is immediately preceded by the phrase "and for the present value of its reasonably to be expected future expenditures for compensation and", we are persuaded that the phrase in question is referring to future "other costs" of that claim, not previously incurred claim costs. Finally, the sentence immediately following the phrase in question provides further clarification that "other costs" refers to future claim costs since all of the costs described in the sentence are future expenditures.

Specifically, the final sentence of ORS 656.593(1)(c) states that "[s]uch other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 and 656.278."

The rationale articulated in Cutsforth and its progeny is likewise applicable to the $297.50 bill stemming from the rescheduled January 1990 IME. As with the February 1990 exam and subsequent report, this expense arose from Tectronix's intention to evaluate the claim. Inasmuch as such an expenditure is not for compensation, first aid, or other medical, surgical, or hospital service, it is not reimbursable. See ORS 656.593(1)(c).

When the $929.50 in bills related to the IME ($632 + $297.50) are deducted from Tectronix's $2,284.40 lien, a balance of $1,354.90 remains. It is uncontested that this remaining portion of Tectronix's lien is recoverable. Consequently, we find that Tectronix has established a paying agency lien against the third party settlement equal to $1,354.90. ORS 656.593(1)(c).

Applying the statutory scheme to our conclusions regarding Tectronix's lien, we conclude that the following distribution of proceeds is "just and proper" under ORS 656.593(3):

Settlement	$5,362.90
Attorney Fee	$1,170.36
Litigation Expenses	$ 10.00
Sub-Total	$4,182.64
Claimant's 1/3 Share	$1,394.21
Remaining Balance	$2,788.43
Tectronix Lien	$1,354.90
Remainder to Claimant	$1,433.53

Rather than distributing the settlement proceeds in accordance with the aforementioned statutory scheme, claimant's counsel distributed them in a manner that increased claimant's share of the recovery by $332.62, ($3,160.36 - ($1,394.21 + $1,433.53)), while reducing Tectronix's portion by $332.72 ($1,354.90 - $1,022.18). As a result of this impermissible distribution, Tectronix's recovery has been unilaterally and invalidly reduced. Under such circumstances, we have previously held that the paying agency may recover the unpaid portion of its lien from claimant's attorney. See Manuel A. Ybarra, 43 Van Natta 376 (1991); Steven B. Lubitz, 40 Van Natta 450 (1988).

In accordance with the reasoning discussed above and the rationale articulated in the Ybarra and Lubitz holdings, we conclude that claimant's attorney is jointly and severally responsible for remedying this situation. Accordingly, claimant and/or claimant's attorney are directed to pay Tectronix its rightful share of the settlement proceeds, i.e., $1,354.90.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID L. VORDERSTRASSE, Claimant
WCB Case No. 86-14401
ORDER ON REMAND
Emmons, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990). The court has concluded that our prior order, David L. Vorderstrasse, 41 Van Natta 2118 (1989), did not contain findings sufficient to explain our conclusion that claimant's work activities were the major contributing cause of his condition. Consequently, the court has remanded for further findings of fact. We proceed with our reconsideration.

We republish our November 20, 1989 Order on Review with the following supplementation.

Our conclusion that claimant's work activities were the major contributing cause of his Raynaud's Phenomenon is based on the following findings. In August 1986, claimant consulted Dr. Ellison, a hand surgeon, for complaints of pain, numbness and decreased circulation in both hands. Dr. Ellison diagnosed Raynaud's Phenomenon and related the condition to claimant's work activities, specifically the vibratory effects of using a pneumatic grinder.

Thereafter, Dr. Button, who is also a hand surgeon, performed an independent medical examination at the insurer's request. After reviewing the medical record and performing grip and pinch tests, Dr. Button agreed that claimant suffered from Raynaud's Phenomenon and also believed that the condition was caused by his prolonged use of a grinder at work.

We find both Dr. Ellison's and Dr. Button's opinions to be well-reasoned and based on complete information. Consequently, we find them persuasive. Somers v. SAIF, 77 Or App 259 (1986).

In reaching this conclusion, we note that neither Dr. Ellison nor Dr. Button quantified the magnitude of the causation in terms of the "major contributing cause." "Magic words," however, are not required. McClendon v. Nabisco Brands, 77 Or App 412 (1986). After our review of the record, we conclude their opinions are sufficiently persuasive to find claimant's work activities to be the major contributing cause of his Raynaud's Phenomenon.

We further add that the only other expert opinion introduced on the issue of medical causation came from Dr. Throop, who believed that claimant's work exposure was not the major contributing cause of his condition. We find Dr. Throop's opinion conclusory and not thoroughly explained. In response to a letter from the insurer's attorney, he merely confirmed that he believed that the work was not the major contributing cause. He offered no explanation or supportive findings. Consequently, we do not find his opinion persuasive and give it little weight. Somers v. SAIF, supra.

On reconsideration, we conclude that the record contains sufficient medical evidence to establish that claimant's work exposure was the major contributing cause to his Raynaud's Phenomenon. Accordingly, with the above supplementation, we adhere to and republish our November 20, 1989 Order on Review in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
AGNES L. COSNER, Applicant
WCB Case No. CV-91003
CRIME VICTIM ORDER
Thomas E. Ewing, Assistant Attorney General

Agnes L. Cosner, (hereafter referred to as "applicant"), has requested Board review of the Department of Justice's January 29, 1991 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on: (1) a failure to file a claim for benefits within one year from the date of the alleged criminal incident; (2) a failure to notify law enforcement authorities within 72 hours of the alleged incident; (3) a failure to fully cooperate with law enforcement officials in the apprehension and prosecution of the alleged assailant; and (4) the lack of evidence that applicant had sustained a compensable loss of more than $100.

Following our receipt of the request for Board review, applicant was advised that she was entitled to present her case to a hearing officer. To exercise her right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed her a copy of its record. The Department mailed a copy of its record to applicant on February 27, 1991. On March 4, 1991, the Board received a letter from applicant discussing her claim and enclosing an estimate of proposed services from a dentist. Applicant did not request a hearing.

Consequently, we have conducted our review based solely on the record. OAR 438-82-030(2). The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings.

FINDINGS OF FACT

On November 2, 1990, the Department received the applicant's October 31, 1990 claim for compensation as a victim of a crime. According to the application, the crime occurred when applicant's sister's "boyfriend" (Fred Brown) inquired into applicant's "sex life." When applicant responded "none of your business," Brown struck her in the mouth, knocking out several of her teeth.

Although the application gave the date of the incident as "10-29-89", another portion of the claim stated that the first notification of the incident to a law enforcement agency happened on "1-18-89." The application further provided that: (1) law enforcement officials were not notified within 72 hours of the incident because applicant was "wait[ing] for an apology from him;" (2) applicant did not cooperate to apprehend/prosecute the assailant because "he said go talk to an attorney about it;" and (3) applicant was not filing her claim within 6 months of the incident because "no one told me about your service and I have had trouble in my family."

In response to applicant's claim for benefits, the Department conducted an investigation. On December 4, 1990, Rita Lanman, the Director of the Union County District Attorney's Victim/Witness Assistance Program, reported that applicant had called her "several weeks ago" about the program. Lanman recalled that applicant had stated that her teeth had been knocked out about a year ago, but that she had not reported the incident because she did not want to get anyone in trouble. Noting that she had contacted the Oregon State Police, Lanman reported that there was no crime report in the name of either applicant or Fred Brown. On December 6, 1990, the Oregon State Police confirmed that it had no record of the alleged incident.

Dr. Rost, the physician listed on applicant's claim, reported that applicant was not seen on the "10-29-89" date of the alleged incident. Sara Price, RN, reported that she had visited applicant's father in her capacity as a home health nurse and had observed applicant's lack of teeth. Describing applicant as "honest and sincere," Price stated that she believed applicant had lost her teeth as a result of being struck by her brother-in-law.

On December 21, 1990, the Department issued its Findings of Fact, Conclusions and Order. The Department found that: (1) the claim was untimely filed; (2) applicant had not reported the incident to law enforcement officials within 72 hours; (3) applicant had not fully cooperated in the apprehension and prosecution of the alleged assailant; and (4) applicant had not sustained a $100 loss as a result of the incident. Inasmuch as applicant had not satisfied ORS 147.015(1), (2), (3), and (6) of the Act, the Department denied her application for benefits.

On December 31, 1990, the Department received applicant's request for reconsideration of its denial. Applicant insisted that she had reported the incident to the "State Police," who "came out and talked to me about it" and "said there was nothing they could do about it." She further stated that the policeman had advised her to seek legal assistance, which she had done.

In support of her contentions, applicant enclosed copies of an executed retainer agreement and correspondence with Mr. Bettis, Attorney at Law. These materials documented that applicant retained Mr. Bettis on May 11, 1989 for the purposes of seeking damages for battery, harassment, and outrageous conduct against Fred Brown arising out of an "October 29, 1988" incident. Bettis made demand on Brown on August 30, 1989 and, on October 9, 1989, notified applicant of his inability to determine the identity or whereabouts of the man who had assaulted her.

Following further consideration, the Department found no basis for altering its prior order. Therefore, on January 29, 1991, the Department issued its Order on Reconsideration, adhering to its December 21, 1990 decision. Thereafter, applicant requested Board review.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 147.015, applicant is entitled to an award under the Act, if, among other requirements:

> "(6) The application for an award of compensation under ORS 147.005 to 147.365 is filed with the department:
>
> (a) Within six months of the date of the injury to the victim; or
>
> (b) Within such further extension of time as the department for good cause shown, allows."

Lack of knowledge of the fund or failure of the investigating officer to provide information as provided in ORS 147.365 is deemed to be "good cause" for extension of the time in which a claim must be filed for an additional six months from the date of expiration as set by ORS 147.015(6)(a). OAR 137-76-030(1). However, in the interest of orderly and consistent administration, no extension of time within which a claim must be filed will be granted beyond one year from the date of the criminal injury for any cause except for mental or physical incapacity directly resulting from the criminal injury sustained. OAR 137-76-030(2).

Here, applicant's claim for benefits was filed with the Department on November 2, 1990. Her October 31, 1990 application noted that the incident occurred on October 29, 1989. However, the date of the incident is subject to question. The application also provides that applicant first notified the police on January 18, 1989, which, if the 1989 incident date was accurate, would be 9 months before the incident. Moreover, applicant's former attorney, Mr. Bettis, was retained on May 11, 1989. Finally, Bettis' August 31, 1989 demand letter to Mr. Brown refers to an "October 29, 1988" injury date.

Such evidence leads to the conclusion that the incident occurred on October 29, 1988, not October 29, 1989, as stated in the application. In any event, even if the incident took place on October 29, 1989, applicant's claim was filed more than one year later. Consequently, the application was untimely.

In explaining the untimeliness of her claim, applicant asserts that she was unaware of the crime victim compensation program and was having "trouble with her family." Concerning the latter explanation, applicant mentions illnesses suffered by her mother and father during this period. The lack of knowledge of the program provides justification for applicant's failure to file the claim between 6 months and one year from the date of the criminal injury. OAR 137-76-030(1). However, extensions of time to file a claim in excess of one year after the injury are granted only if the failure to timely file was the result of mental or physical incapacity directly resulting from the criminal injury. OAR 137-76-030(2). No such explanation has either been asserted or found in this record. Accordingly, we conclude that the claim was filed untimely.

Even assuming that the claim was timely filed, several other statutory requirements have not been satisfied. In particular, ORS 147.015(2), and (3) require the notification of appropriate law enforcement officials within 72 hours of the injury and the applicant's full cooperation in the apprehension and prosecution of the assailant. Applicant has not met either prerequisite.

Here, the application for benefits acknowledges that officials were not notified within 72 hours of the injury. Such a time requirement can be waived upon a demonstration of "good cause," which means physical or mental incapacity to report the crime. ORS 147.015(2); OAR 137-76-010(6). Applicant's excuse for the untimely notification was that she was awaiting an apology. A delay in notifying authorities to obtain an apology does not constitute physical or mental incapacity to report the crime. Consequently, we hold that the requirements of ORS 147.015(2) have not been satisfied.

Furthermore, applicant concedes that she did not cooperate to apprehend/prosecute the assailant. She explains that the police suggested that she retain an attorney. The failure to cooperate with law enforcement officials can be excused upon a showing of "good cause," which in this respect means that the applicant failed to cooperate because she was in reasonable fear of threat of death or serious physical injury. ORS 147.015(3); OAR 137-76-010(5). No such allegation has either been offered nor found in this record to explain applicant's failure to cooperate in the apprehension and prosecution of her assailant. Therefore, ORS 147.015(3) has not been met.

Finally, ORS 147.015(1) requires a compensable loss of more than $100. The record before the Department failed to document any loss as a result of the assault. On review, applicant has submitted a September 16, 1990 "Estimate of Dental Services to be Performed" from Dr. Shader, DMD, that lists costs of potential services totalling approximately $1,213. Inasmuch as this estimate was not part of the record considered by the Department, it is not admissable. ORS 147.155(5). However, even if it was considered, it would not establish that such services have been provided and the expense actually incurred. Moreover,

even if the estimated costs were incurred, applicant's claim would still not have satisfied ORS 147.015(2), (3), and (6). Therefore, her application for benefits would remain denied.

In conclusion, we regret the emotional, physical, and potentially financial pain which this unprovoked assault has caused applicant. Yet, to recover benefits as a victim of a crime under the Act, specific prerequisites must be satisfied. Unfortunately, as detailed above, several of these statutory requirements have not been met. Accordingly, applicant's claim for benefits must be denied.

ORDER

The December 21, 1990 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered January 29, 1991, is affirmed.

April 18, 1991 Cite as 43 Van Natta 926 (1991)

In the Matter of the Compensation of
LINDA A. FUCHS-PERRITTE, Claimant
WCB Case Nos. 89-16754, 89-16335, 89-16334, 89-08739 & 89-15256
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Kathryn L. Wilske (Saif), Defense Attorney
Pamela Schultz, Defense Attorney
Darrell E. Bewley, Defense Attorney

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation, on behalf of Bob Kimmel Trucking, requests review of those portions of Referee/Arbitrator Lipton's order that: (1) set aside its denials of claimant's aggravation claim for her neck injury; (2) upheld Liberty Northwest's denial, on behalf of Pappy's Pizza, and the SAIF Corporation's denial, on behalf of Satellite Motel, of claimant's "new injury" claim for her current neck and headache condition. Liberty Northwest contends, in part, that the Referee incorrectly concluded that it was precluded from litigating compensability of the claim. In the event the Referee's responsibility determination is affirmed, Liberty argues that it should not be required to reimburse SAIF for temporary disability benefits and medical services provided to claimant by SAIF. In its brief, SAIF contends that Exhibit 58 should be stricken from the record. On review, the issues are evidence, compensability (if properly raised), responsibility, and reimbursement. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

On July 31, 1989, Liberty Northwest, on behalf of Bob Kimmel Trucking, amended its prior April 19, 1989 responsibility denial to include a denial of compensability. Copies of this denial were sent to both the Compliance Section and SAIF. (Ex. 46; Tr. 29). Liberty continued to assert compensability as a defense to the claim at hearing.

In its August 3, 1989 responsibility denial, SAIF indicated that it intended to request designation of a paying agent pursuant to ORS 656.307. This denial was issued approximately two weeks before an order designating SAIF as paying agent pursuant to ORS 656.307 was issued.

Claimant's compensable 1986 injury remained a material cause of her condition as of March 1989.

CONCLUSIONS OF LAW AND OPINION

Evidence

SAIF contends that Exhibit 58, relied upon in Liberty Northwest's brief on behalf of Bob Kimmel Trucking, is not properly a part of the record on review. Exhibit 58 is an April 25, 1990 "check-the-box" response from Dr. Karr, M.D., indicating that claimant's employment activities (including work for SAIF's insured) independently contributed to a worsening of her underlying spinal and shoulder condition. SAIF contends that the exhibit should be excluded because the record was left open for only 30 days following the November 21, 1989 hearing to allow claimant to submit additional information from Dr. Karr.

We agree that the Hearings Referee indicated her desire that the record be closed within 30 days. However, the Referee at hearing subsequently left the Board's employ without closing the record. The record was subsequently closed by Referee Lipton on June 21, 1990, which was after submission by Liberty of Dr. Karr's report. Moreover, at hearing, Liberty expressly requested permission to cross-examine or depose Dr. Karr. (Tr. 105) We conclude that the Referee did not abuse his discretion by receiving Exhibit 58 into the record.

Moreover, we note that Exhibits 51 through 57 were also submitted post-hearing. No party has objected to inclusion of these exhibits in the record. Further, it does not appear that these exhibits were obtainable with due diligence prior to the hearing. See Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988) (Remand inappropriate where evidence obtainable prior to hearing). Accordingly, we conclude that, although not expressly received into evidence at hearing, those exhibits were impliedly received and are also properly included in the record on review.

Scope of Issues

The Referee concluded that Liberty Northwest was precluded from contesting compensability of claimant's claim. The Referee reasoned that the Director's ORS 656.307 order stating that responsibility was solely at issue, and which appointed SAIF as paying agent pending resolution of the responsibility issue, was controlling. In addition, the Referee concluded that Liberty Northwest was prohibited by the policy set forth in Bauman v. SAIF, 295 Or 788 (1983), from "back-up" denying an accepted condition.

Where the employers/insurers concede compensability and a ".307" order subsequently issues, we treat that order as a formal acceptance of compensability by the employers/insurers. Judy Witham, 40 Van Natta 1982, 1986 (1988). Thereafter, the employers/insurers may not deny the compensability of the claim absent a showing of fraud, misrepresentation or other illegal activity. See Bauman v. SAIF, supra.

Here, Liberty Northwest's initial denial was one of responsibility only. Subsequently however, but still prior to the issuance of the ".307" order, Liberty amended its denial to include compensability as well as responsibility. Inasmuch as this clarification occurred prior to the issuance of the ".307" order, Bauman is not applicable. See Steven P. Burg, 42 Van Natta 121, 122 (1990); see also Ronald W. Davis, 42 Van Natta 1213 (1990). Therefore, Liberty Northwest was not precluded from raising compensability as a defense to the claim.

Standard of Review

ORS 656.307 currently provides for formal arbitration of responsibility cases. Subsection (2) provides that the Director initiate the arbitration proceeding by referring the matter to the Board for appointment of the arbitrator. The referral is made by issuing a ".307" order. We generally review an arbitrator's responsibility decision only for errors of law. ORS 656.307(2); see John L. Riggs, III, 42 Van Natta 2816, 2877 (1990).

Here, the matter was referred to the Board through issuance of a ".307" order. In addition, the Referee titled his opinion as an "Arbitrator's Decision." However, because Liberty Northwest raised compensability as an issue prior to issuance of the ".307" order, we conclude that the order under review is that of a referee rather than an arbitrator, and our review is, therefore, de novo based upon the hearing record. ORS 656.704 and 656.295.

Compensability/Responsibility

We have concluded that Liberty Northwest has raised compensability of the claim as an issue. In a case involving both compensability and responsibility, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 499 (1987).

With regard to compensability, Liberty Northwest states in its brief on behalf of Bob Kimmel Trucking that "the medical record does not support the conclusion that claimant's problems in March 1989 and thereafter are/were related to her 1986 injury." In support, Liberty argues that there is no medical evidence of any permanent impairment related to claimant's compensable 1986 injury while employed by Bob Kimmel Trucking. We do not agree.

The medical record establishes that claimant has experienced persistent and chronic neck symptoms and headaches, varying only as to frequency and degree, since the compensable 1986 injury. Liberty nevertheless argues that the medical evidence is not persuasive in light of the Referee's finding that claimant has a "tendency towards histrionics." Such a finding, if supported by the record, would lead us to question the severity of claimant's symptoms as reported by her. However, such a finding does not lead us to doubt whether, in fact, claimant experiences any symptoms. Nor are there other reasons in the record to question claimant's reporting of chronic symptoms since the 1986 injury. In addition, claimant has received a permanent disability award for her 1986 injury pursuant to a February 1988 stipulation. Therefore, we conclude that claimant has carried her burden to establish a causal relationship between her 1986 compensable injury and her condition at and after March 1989. Accordingly, her claim is compensable.

We turn next to the issue of responsibility. Where a claimant has an accepted compensable injury or occupational disease followed by an increase in disability during later employment(s), responsibility is fixed with the carrier who initially accepted the claim. In order to shift responsibility, the original carrier must prove affirmatively that a later employment independently contributed to a pathological worsening of the underlying condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986). The Referee concluded that, subsequent to her employment with Bob Kimmel Trucking, claimant's condition merely worsened symptomatically. We agree.

The only medical report supporting a finding that claimant's underlying condition pathologically worsened following her employment with Bob Kimmel

Trucking is Exhibit 58, Dr. Karr's April 1990 "check-the-box" concurrence with a statement to the effect that all of claimant's employments had contributed to a worsening of her underlying condition. This opinion is conclusory and, therefore, lacks persuasiveness. In addition, Dr. Karr previously opined, in July 1989, that claimant had experienced no new and separate injury; that claimant's condition was merely a continuation of previous symptoms; and that there had been no recent aggravation. (Ex. 46A). These conclusions would appear to conflict with Dr. Karr's April 1990 "check-the-box" opinion. In sum, the only medical opinion supporting a pathological worsening of claimant's underlying condition is conclusory and contradicts prior opinions. It is, therefore, unpersuasive.

Liberty contends that portions of claimant's testimony also support a pathological worsening of claimant's condition. However, we first note that, given claimant's multiple complaints and employment exposures, resolution of this issue is largely dependent upon the medical evidence addressed above, i.e., claimant's lay testimony is of only limited persuasive value. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). In addition, while claimant testified that she was worse following her employment with SAIF's insured, her medical history establishes multiple periods of waxing and waning of symptoms. Moreover, claimant reported to Drs. Phipps and Fuller in August 1989, that her headaches had not changed prior to her employment with SAIF's insured. (Ex. 47). We conclude that claimant's testimony alone is insufficient to establish a pathological worsening of her condition. Responsibility for her condition remains with Liberty Northwest, on behalf of Bob Kimmel Trucking.

Reimbursement

Liberty contends that it should not be required to reimburse SAIF, paying agent pursuant to the ".307" order, for certain temporary disability benefits and medical services provided to claimant by SAIF. However, our jurisdiction is restricted to matters concerning a claim, which is defined as those matters in which "a worker's right to receive compensation, or the amount thereof, are directly at issue." ORS 656.704(3); ORS 656.726(2). Reimbursement disputes between insurers are not matters concerning a claim. EBI Companies v. Kemper Group Ins., 92 Or App 319 (1988); Reynolds-Croft, Inc. v. Bill Morrison Co., 55 Or App 4877 (1982). Reimbursement between carriers is authorized by order from the Director of the Department of Insurance and Finance, not this Board. ORS 656.307(3); Liberty Northwest Ins. Corp. v. SAIF, 99 Or App 729 (1989).

Claimant is entitled to a carrier-paid attorney fee pursuant to ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $500, to be paid by Liberty Northwest on behalf of Bob Kimmel Trucking. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 13, 1990 is affirmed. Claimant's counsel is awarded a reasonable assessed attorney fee of $500, to be paid by Liberty Northwest Insurance Corp. on behalf of Bob Kimmel Trucking.

In the Matter of the Compensation of
CHARLES M. MARSHALL, Claimant
WCB Case No. 90-01203
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Livesley's order that upheld the insurer's denial of his injury claim for a left shoulder and back condition. In its brief, the insurer objects to the Referee's penalty and attorney fee award for unreasonable delay in payment of physical therapy bills. On review, the issues are compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant has had recurrent back and shoulder problems since a 1983 motor vehicle accident (MVA) wherein he dislocated his left shoulder, among other injuries. (Tr. 8, 10, 16,). Noncompensable June and September 1989 injuries affected the same body parts that had been symptomatic since the 1983 MVA, i.e., neck, left shoulder and low back. (Ex. 7; Tr. 23, 24). Claimant has treated regularly over the years for recurring back problems. The most recent chart note, prior to December 1989, is dated November 22, 1989. (Ex. 3A-4).

On December 6, 1989, claimant fell at work and injured his left wrist and hand. After the fall, he immediately sought treatment for left wrist pain and his condition was diagnosed as a wrist sprain. (Ex. 10). He first experienced shoulder problems, following the wrist injury, on about December 18, 1989.

On the initial "801" and "827" forms, and in his initial medical history, claimant described himself as having landed on his left wrist when he fell. (Exs. 8-11). In a January 10, 1990 medical history and on a January 16, 1990 "827" form, claimant related that he fell on his left wrist, elbow and shoulder. (Exs. 12 & 14).

The insurer accepted the wrist injury and later, by stipulation, the elbow condition. It denied the shoulder and back conditions on February 2, 1990.

A telephone note indicates that some of claimant's physical therapy bills had been received by the insurer on April 5, 1990. (Ex. 22-3).

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant bears the burden of proving that an industrial injury materially contributed to his disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). Likewise, in the case of a preexisting condition, claimant must establish that the industrial injury was a material cause of a worsening of the preexisting condition. Grace v. SAIF, 70 Or App 511 (1985); Jameson v. SAIF, 63 Or App 553 (1983).

Because of the multiplicity of potential causes, the causation issue is a complex medical question. The resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967): Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). When, as here, there is a dispute between medical experts, we rely on those medical

opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Spady, orthopedist, examined claimant on February 14, 1990. Spady concluded that claimant's shoulder and back problems were not related to the fall, because of his long prior history of recurrent back and shoulder complaints and treatment, coupled with the delay in onset of these symptoms following the fall. (Ex. 17-14).

Dr. Schlessinger, M.D., agreed with Spady's report, except that he was troubled by his impression that claimant had been asymptomatic prior to the December fall. (Ex. 19B). Inasmuch as claimant sought treatment for his shoulder and back in November 1989 and, therefore, was not asymptomatic in that respect, we conclude, as did the Referee, that Schlessinger effectively concurs with Spady.

The only medical opinion which relates claimant's current back and shoulder problems to the December 1989 incident is that of Dr. Dreger, treating naturopath. We are not persuaded by Dreger's opinion, for the following reasons.

First, Dreger's opinion regarding causation is conclusory. Second, although he treated claimant following both the June and September 1989 incidents, Dreger apparently failed to consider the potential contribution of those alleged injuries to claimant's current problems. Moreover, there is no evidence that Dreger considered claimant's longstanding left shoulder separation as a possible contributing factor to the current symptoms. Finally, we give greater weight to the opinion of Dr. Spady, than we do to that of the treating naturopath, based on Spady's expertise as an orthopedist which is relevant to evaluating claimant's condition. See Abbott v. SAIF, 45 Or App 567, 661 (1980).

For the above reasons, we are persuaded by the opinion of Drs. Spady and Schlessinger rather than by that of Dr. Dreger. Therefore, we conclude that claimant has not established that his current back and shoulder conditions are materially related to his December 1989 work injury. Consequently, claimant's back and shoulder conditions are not compensable.

Penalty and attorney fee

The Referee assessed a penalty and related attorney fee for the insurer's unreasonable delay in acceptance or denial of claimant's medical services claim, due to the insurer's nonpayment of certain physical therapy bills. On review, the insurer contends that the assessment was improper because it did not formally deny the medical services, nor did claimant establish that 60 days passed following notice of the claim. See Syphers v. K-W Logging, 51 Or App 769 (1981). The insurer also argues that claimant has not proven that the physical therapy was provided for a compensable condition.

A claim is a written request for compensation, including payment for medical services, from the worker or someone on the worker's behalf. ORS 656.005(6) & (8). The insurer must accept or deny a claim for medical services within 60 days of notice or knowledge of the claim, or risk imposition of penalties and attorney fees for unreasonable delay. Former ORS 656.262(6) & (10); ORS 656.382(1); Billy J. Eubanks, 35 Van Natta 131 (1983).

The record indicates that the insurer had notice of the medical services claim by April 5, 1990. (Ex. 22-3). The hearing was held on May 22, 1990, but the record remained open until June 20, 1990 so that the insurer could submit evidence on the penalty issue. (See Tr. 3, 55). No such evidence was submitted. Inasmuch as 60 days passed following notice of the claim, without

acceptance or denial, there has been a "de facto" denial of the medical services claim. Because the delay is unexplained, it is unreasonable. See Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984).

However, to support the assessment of a penalty for unreasonable delay, there must be an unpaid "amount then due" during the delay period. See Jeffrey D. Dennis, 42 Van Natta 857 (1991); George Violett, 42 Van Natta 2467 (1990); Harold A. Lester, 37 Van Natta 745, 747 (1985). Although the physical therapist's billing records indicate that bills were submitted to the insurer, claimant has not proven, on this record, that the bills in question were for treatment of a compensable condition. Rather, the first page of the records bears a notation: "Dx: (L) Shldr strain." (Ex. 22-1). Inasmuch as claimant's shoulder condition is not compensable, the outstanding physical therapy bills have not been shown to represent compensable medical services. See former ORS 656.245. Therefore, claimant has not established that there were "amounts then due" and there is no basis for a penalty. See Ellis v. McCall Insulation, 308 Or 74, 78 (1989).

Unlike a penalty, an attorney fee can be awarded even though there are no "amounts then due," provided that the insurer has otherwise unreasonably resisted the payment of compensation. Cindy Cadieux, 41 Van Natta 2259 (1989). Here, inasmuch as the unpaid bills have not been shown to have been for a compensable condition, they have not been shown to have been "compensation." Ellis, supra. Therefore, there has been no showing of unreasonable resistance to the payment of compensation and there is no basis for an attorney fee award.

ORDER

The Referee's order dated June 21, 1990 is reversed in part and affirmed in part. The Referee's penalty and attorney fee award is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
EDWARD L. SULLIVAN, Claimant
WCB Case No. 90-02224
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brown's order that increased his unscheduled permanent disability for a low back injury from 5 percent (16 degrees), as awarded by notice of closure, to 10 percent (32 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's "Findings," with the exception of the findings numbered (4), (5) and (7). In addition, we add the following supplementation.

Claimant was 40 years of age at the time of hearing. He has earned a GED certificate. Claimant's highest SVP value for the ten years prior to the date of hearing was 7 as a service writer. In performing his job as a service writer, claimant acquired training sufficient to perform something other than an entry-level position.

Prior to his injury, claimant was occasionally required to lift assemblies weighing approximately 70 to 75 pounds. Following his injury, claimant was unable to lift the assemblies.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was entitled to 10 percent unscheduled permanent disability under the standards. We apply the "standards" in effect on December 28, 1989, the date of the notice of closure, and modify.

Age

The appropriate value for claimant's age of 40 years is 1. Former OAR 436-35-300(4).

Formal education

The appropriate value for claimant's GED certificate is 0. Former OAR 436-35-300(3)(a).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" values assigned to various occupations by the Dictionary of Occupational Titles (DOT). Claimant's highest SVP value during the ten years prior to the date of hearing was 7 as a service writer (DOT# 620.261-018). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Training

We have concluded that competence in a "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Here, prior to the injury, claimant had worked for the employer for six years. He testified that it had taken him approximately two years to become proficient in his job as a service writer. Under the circumstances, we conclude that claimant has acquired sufficient training as a service writer to perform other than an entry-level position. Therefore, the appropriate training value is 0.

Adaptability

Claimant argues that the Referee incorrectly found that he had returned to his regular work. Following back surgery, claimant returned to work for his employer at his previous position, however, he contends that his job duties were modified.

Prior to his injury, claimant's work required that he lift over 50 pounds, which is classified as heavy work. Former OAR 436-35-310(4)(a). After returning to work, claimant did not engage in heavy lifting, because of his back. Claimant argues that his duties had been modified because of his back condition. In addition, Dr. Louie reported that claimant should avoid lifting over 50 pounds frequently.

Claimant asserts that the administrative rules which provide that a claimant who returns to regular work shall be assigned no value for age, education and adaptability, are invalid. See former OAR 436-35-240(a); OAR 436-35-300(a); OAR 436-35-310(a). Claimant argues that the rules are invalid because they

preclude consideration of factors which the enabling statute provides must be considered in determining disability. See ORS 656.726(3)(f)(A).

Claimant argues, in the alternative, that the Referee was required to rate his disability at the time of hearing. Claimant contends that at the time of hearing, he was employed as a dispatcher, rather than a service writer, and the Referee should have found that he had returned to sedentary work.

Although we agree that the Referee correctly concluded that claimant had returned to his work with the employer, we do not agree that claimant returned to his usual and customary work. Claimant testified that, prior to his injury, he was occasionally required to lift weights of approximately 70 to 75 pounds. Although his doctor, in effect, released claimant to heavy work, claimant testified that, because of his back, he would probably not be able to perform that aspect of his job that required him to occasionally lift 75 pounds.

We conclude that claimant returned to modified work, rather than to his usual and customary work. "Modified work" means some job other than the job held at the time of injury or the job held at the time of injury with any modification of duties or the conditions under which those duties are performed. Former OAR 436-35-270(3)(b).

Here, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a medium physical capacity. See former OAR 436-35-270(3)(b). See also C. Bernice Chandler, 43 Van Natta 899 (1991) (Although claimant's usual and customary work was heavy and she had been released to regular work, claimant herself found it necessary to modify her duties and was actually performing work in the medium category). Accordingly, the appropriate adaptability value is 1. Former OAR 436-35-310(3)(a).

Finally, we disagree with claimant's contention that the Referee was required to assign an adaptability value based upon the capacity required by his job at the time of hearing. Claimant had returned to his job-at-injury and subsequently left work for reasons unrelated to his compensable injury. We, therefore, agree with the Referee that claimant returned to his at-injury employment. See David C. Arabia, 42 Van Natta 1798 (1990).

We note that, because we have not found that claimant returned to usual and customary work, we do not address his argument regarding the validity of the administrative rules pertaining to a return to usual and customary work.

Impairment

The parties do not dispute, and we conclude, that the Referee correctly assigned an impairment value of 5 percent for his laminectomy with single discectomy at the L3-4 level. Former OAR 436-35-350(2). In addition, it is not disputed, and we conclude, that claimant is entitled to a value of 5 percent for his chronic condition limiting repetitive use of his back. Former OAR 436-35-320(4). The 5 percent value for claimant's surgical procedure is combined with the 5 percent impairment value for limited repetitive use of his back for a total impairment value of 9.75.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 1, the sum is 2. When that value is multiplied by claimant's adaptability value, 1, the product is 2. When that value is added to claimant's impairment value of 9.75, the result is 11.75

percent unscheduled permanent disability. That value is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 12 percent.

ORDER

The Referee's order dated July 3, 1990 is modified. In addition to the Referee's award and the notice of closure award, claimant is awarded 2 percent (6.4 degrees), giving him a total award to date of 12 percent (38.4 degrees) unscheduled permanent disability for his low back condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney by the SAIF Corporation. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
HELEN M. CHASE, Claimant
WCB Case No. 90-05487
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

The SAIF Corporation requests review of those portions of Referee Hoguet's order that: (1) set aside its denial of an aggravation claim for claimant's low back condition; and (2) assessed an attorney fee for untimely denial. Claimant cross-requests review of that portion of the order that declined to award temporary total disability compensation. On review, the issues are aggravation, attorney fees and temporary total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Ultimate Findings of Fact".

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's "Conclusions and Opinion" with regard to the aggravation issue with the exception of the final paragraph of that section, which addresses interim compensation or temporary total disability compensation.

Temporary Total Disability Compensation

The Referee concluded that claimant was entitled to no interim compensation or temporary total disability compensation because there was no medical verification of inability to work. On review, claimant contends that medical verification of inability to work is not required. We agree.

The duty to pay compensation between the filing of a claim for aggravation and issuance of a denial does not attach unless or until the insurer receives medical verification of the inability to work. Silsby v. SAIF, 39 Or App 555 (1979). To establish entitlement to temporary disability compensation at hearing, however, claimant may rely on lay evidence of disability. She need not adduce expert medical evidence of disability. See e.g., Botefur v. City of

Creswell, 84 Or App 627 (1987). We are persuaded, on the record as a whole, that claimant was more disabled due to the worsening of her condition.

Nevertheless, we are not persuaded that claimant is entitled to additional temporary disability compensation. Claimant is only entitled to such compensation if she was in the workforce at the time of the aggravation. When, as here, a worker is not employed at the time of the worsening, she is entitled to compensation only if she is willing to work and making reasonable efforts to obtain employment or she is willing to work but efforts to seek work would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989).

Claimant has not worked since she quit work in October 1987 for reasons unrelated to the injury. There is no evidence that she made any effort to find work since that time although she was concededly capable of work. Hence, she is entitled to no temporary disability compensation on the aggravation claim.

Attorney Fee for Untimely Denial

We adopt that section of the Referee's "Opinion and Conclusions" titled "Penalty and Attorney Fee for Late Aggravation Denial."

SAIF requested review of the Referee's order regarding the aggravation issue; we have concluded that claimant's compensation should not be disallowed or reduced. Hence, claimant is entitled to an attorney fee under ORS 656.382(2).

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's attorney's services on review on the aggravation issue is $400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as reflected in the quality and extent of the brief), the minimal complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 18, 1990 is affirmed. For services on Board review on the aggravation issue, claimant's attorney is awarded an assessed fee of $400, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
S. JENIKA, Claimant
WCB Case Nos. 88-18083 & 88-16839
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee Lipton's order that set aside its denial of claimant's occupational disease claim for her current stress condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant worked for the employer as a vocational consultant from April 1986 through August 1988. Claimant's duties included providing vocational rehabilitation assistance to injured workers. In January 1987, a national vocational rehabilitation corporation purchased claimant's company. Following the takeover, counselors were under increased pressure to produce work and to account for billable hours. A system including bonuses and productivity "report cards" was implemented by the new employer.

From 1987 through summer 1988, the employer had a high turnover rate of both clerical staff and vocational counselors. During that same period, the employer's caseload declined.

In July 1988, following a low billable month by claimant's division, her supervisor, Lannie McGuire, was fired. In mid-July, claimant began to experience symptoms of headaches, anxiety and insomnia. Claimant also experienced stomach problems, diarrhea and mild weight loss.

On August 23, 1988, while in a meeting at work, claimant suffered a seizure. Dr. Larsen, M.D., diagnosed a stress-induced grand mal seizure. Following the seizure incident, claimant was unable to return to work. She filed a claim for anxiety and depression.

On September 22, 1988, the insurer denied claimant's claim for what it characterized as work-related stress.

Over the next several months, claimant received therapy and medical treatment for physical and emotional symptoms diagnosed as stress and anxiety related.

In a Stipulation and Order of Dismissal approved on March 28, 1989, the insurer accepted claimant's seizure incident of August 23, 1988. Claimant's request for hearing, to the extent that it addressed the isurer's denial of the seizure, was dismissed. The denial of claimant's "stress claim" remained in effect, subject to the hearing in this matter.

Claimant had previously sought mental health counseling in March 1985. She again sought treatment from April through December 1987.

In 1988, claimant had physical health problems including a strained left knee and a stiff neck. She also suffered from an ear condition which later required surgery.

ULTIMATE FINDINGS

Claimant suffered a mental disorder, an adjustment disorder with mixed emotional features, anxiety and depression, the cause or worsening of which arose out of and in the course of her employment. That mental disorder required medical treatment and resulted in disability.

Employment conditions which existed in a real and objective sense included billing practices, a diminishing caseload, increased pressures to produce, high staff turnover and a requirement that vacation or sick leave be made up on an employee's own time before bonus time could be accrued. Claimant's employment conditions contributed in material part to her mental disorder.

The conditions which resulted in claimant's disabling mental disorder were not conditions generally inherent in every working situation. The conditions were not disciplinary, corrective or job performance evaluation actions and were not associated with the cessation of employment.

Claimant's condition was diagnosed as an adjustment disorder by Dr. Colbach, psychiatrist. That condition is a mental disorder generally recognized in the psychological community.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because the insurer had accepted claimant's seizure, it was also required to accept the cause of the seizure, i.e., her "stress" condition. The insurer argues that the seizure was a discrete incident (injury) and it did not accept the occupational disease. We agree with the insurer's contentions.

Claimant suffered a seizure at work on August 23, 1988. Her treating neurologist, Dr. Smith, noted that claimant had not been sleeping well for three weeks prior to the seizure. He reported that claimant had recently been under a great deal of stress at work. Dr. Smith opined that the emotional stress claimant had been experiencing at work with the attendant sleep impairment played a significant precipitating role in the occurrence of the seizure.

On November 3, 1988, Dr. Colbach, M.D., examined claimant for the insurer and diagnosed adjustment disorder with mixed emotional features, anxiety and depression. He reported that "quite a bit" was expected of claimant in her job, and because she could not handle things, she "did break down emotionally to some extent." Dr. Colbach reported that claimant's physical problems included her epileptic seizure, but he deferred to Dr. Smith on the issue of whether the seizure was related to stress at work.

In December 1988, Dr. Smith reported that the exact etiology of the seizure had not yet been defined. He stated that a negative MRI ruled out structural abnormalities and he discounted the effects of a 1980 concussion. He believed that, although the exact cause of the seizure had not been defined, work-related stress played a major contributing role in causing the seizure to occur when it did. He also reported that emotional stress and sleep deprivation were both recognized as triggers for seizure activity.

On December 14, 1988, Dr. Larsen, claimant's treating psychiatrist, agreed that work events occurring subsequent to April 1, 1987 and up to the present, were the major contributing cause of her stress. He also opined that on-the-job work events occurring after April 1, 1987, contributed directly to claimant's seizure.

In Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the Court stated that the question was whether acceptance of a claim for a condition included acceptance of the compensability of the disease causing that condition. The Court held that, because the insurer accepted a claim for a sore back (a symptom), it could not deny the underlying disease of spondylitis (the cause of the symptom), which was not a separate condition. Piwowar, supra. See also SAIF v. Abbot, 103 Or App 49 (1990).

Here, the medical opinions do not state that the mental disorder is inseparable from the seizure. Nor does the evidence establish that claimant's seizure was a symptom of a "mental disorder" rather than a direct consequence of job stress. We, therefore, decline to apply the analysis set forth in Piwowar. In addition, the Court has held that if an insurer specifically accepts in writing only one of several conditions or injuries encompassed by a single claim, the insurer has not "specifically" or "officially" accepted the other conditions allegedly related to the accepted part of the claim. Johnson v. Spectra Physics, 303 Or 49 (1987).

Here, in a Stipulation and Order of Dismissal approved on March 28, 1989, the insurer accepted claimant's August 23, 1988 seizure incident. However, the stipulation recited that it "resolved only the issue of claimant's seizure incident" and the "September 28, 1988 denial of claimant's stress claim remains in full force and effect." Under the circumstances, we conclude that the insurer did not accept claimant's stress condition at the same time it accepted her seizure incident.

Because the Referee concluded that the insurer had accepted claimant's claim for her mental disorder, he did not consider the merits of her claim for a mental disorder. However, as the denial of the psychological condition was before the Referee and the record was fully developed, we consider the merits of the claim.

Compensability under ORS 656.802

The date of "injury" for purposes of determining the compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions that caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986). Here, claimant's occupational disease claim for her current psychological condition alleges exposure to potentially causal employment conditions occurring after January 1, 1988. Accordingly, the occupational disease law which became effective January 1, 1988, is applicable. See Johnson, supra at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

ORS 656.802 provides, in part, that an occupational disease arising out of and in the course of employment which requires medical services will not be compensable:

> "(2)(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> " (b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.

> " (c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> " (d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

In the present case, the record shows that the employment conditions which caused claimant's mental disorder existed in a real and objective sense. Ms. Rosenthall, M.S.W., reported that one of the major sources of claimant's stress and physical symptoms was the pressure she felt from her job. Dr. Smith noted that claimant had been under increasing pressure from her supervisor to increase her performance. Dr. Larsen reported that work events occurring subsequent to April 1, 1987 were the major contributing cause of claimant's stress.

Dr. Colbach, M.D., performed a psychiatric evaluation of claimant for the insurer. Following the evaluation, he reported that claimant was oriented and her memory was intact. Dr. Colbach also found that claimant's thought processes were well organized and there was no evidence of any kind of hallucinations or delusions. He noted that "quite a bit was expected of claimant in her most recent job." Dr. Colbach concluded that claimant's job was a major contributing factor to her current breakdown.

Claimant and her co-workers testified that, following a change of supervisors and adoption of a new policy in regard to billing procedures, they had been under increased pressure to produce work. Employees who took vacation or sick leave were required to make up time in order to maintain production and before they could accrue bonus time. Employees were subject to caseload reductions but were nonetheless expected to meet an 80 percent productivity rate (i.e., to bill 80 percent of their work time to a client).

Claimant reported to Dr. Colbach that she found it difficult to engage in the "creative billing" which took place at work, which meant that more than one insurer was billed for the same piece of time. Claimant was required to work more and she was having difficulty sleeping because of the pressure at work. We conclude that claimant's testimony, the testimony of other employees and the report of Dr. Colbach establish that the conditions which claimant complained of did exist in a real and objective sense.

In the present case, claimant's mental disorder is one generally recognized in the medical or psychological community. In 1987, Ms. Rosenthall, MSW, diagnosed claimant's condition as an anxiety disorder DSM III 300.02. In October 1988, Dr. Larsen, M.D., examined claimant and diagnosed severe acute stress reaction (DSM 308.30) accompanied by a stress-induced grand mal seizure (DSM 316.00). In November 1988, Dr. Colbach, M.D., examined claimant and diagnosed adjustment disorder with mixed emotional features, anxiety and depression.

In arriving at his opinion, Dr. Colbach performed a psychiatric evaluation of claimant, reviewed the medical reports supplied by the insurer and took claimant's history. We are persuaded by Dr. Colbach's complete and well-reasoned opinion. Based upon Dr. Colbach's diagnosis, we conclude that claimant's mental disorder is one generally recognized in the medical or psychological community.

In the present case, claimant has shown by clear and convincing evidence that her mental disorder arose out of and in the course of employment. Dr. Colbach reported that claimant's job was a major contributing factor to her current breakdown. Dr. Larsen reported that work events occurring subsequent to