VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 44

(Pages 1-656)

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

44 Van Natta ____ (1992)

In the Matter of the Compensation of
DARCINE L. FOX, Claimant
WCB Case No. 91-02878
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Gunn and Kinsley.

The SAIF Corporation requests review of those portions of Referee Holtan's order that: (1) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to pay scheduled permanent disability at the correct rate. On review, the issues are the rate of scheduled permanent disability and penalties. We affirm in part and reverse in part.

Rate of Scheduled Permanent Disability

We affirm and adopt the portion of the Referee's order which addressed the rate of claimant's scheduled permanent disability, with the following supplementation.

The Referee concluded that claimant's December 28, 1990 award of scheduled permanent disability should be paid at the rate of $305 per degree. We agree.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the amendment to ORS 656.214(2), in 1990 Oregon Laws, chapter 2, section 7 which increased the value per degree of scheduled permanent disability to $305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because claimant's award of scheduled permanent disability was made after May 7, 1990, the Referee correctly concluded that the award should be paid at the rate of $305 per degree.

Penalties and Attorney Fees

The Referee assessed penalties and attorney fees under ORS 656.262(10) for SAIF's allegedly unreasonable failure to pay claimant's compensation at the correct rate. We do not agree. The insurer contends, and we agree, that its conduct was reasonable because it followed a validly enacted rule when calculating the payments. See former OAR 436-35-010(5); (eff. October 1, 1990). Mary E. Weaver, 43 Van Natta 2618, 2619 (1991) ("As a general rule, we do not in such circumstances, assess a penalty; for to do so would penalize the insurer for complying with a valid administrative rule.").

Claimant's attorney is entitled to an assessed attorney fee for prevailing against SAIF's request for review. See 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 rate of permanent disability issue is $300, to be paid by the SAIF Corporation. 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 27, 1991 is affirmed in part and reversed in part. That portion of the order that assessed a penalty is reversed. The

remainder of the order is affirmed. For services on Board review, concerning the rate of permanent disability issue, claimant's attorney is awarded an assessed attorney fee of $300, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JACK S. MABE, Claimant
WCB Case No. 90-18262
ORDER ON REVIEW
Sherwood & Coon, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Hoguet's order which upheld United Employers Insurance Company's ("UEI") denial of compensability of and responsibility for his low back condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant's claim against SAIF, which was scheduled to be heard at the same time as this matter, was settled prior to hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions and reasoning on the compensability issue.

Responsibility

The Referee determined that claimant's employment at UEI's insured did not independently contribute to a pathological worsening of claimant's underlying condition and concluded that SAIF remained responsible for claimant's low back injury.

We agree with the Referee that responsibility for claimant's low back condition remains with SAIF, but we analyze this matter under the Workers' Compensation Act as amended by Senate Bill 1197, effective July 1, 1990. Ida M. Walker, 43 Van Natta 1402 (1991). We have held that under Section 49 of Senate Bill 1197, a carrier that is responsible for a compensable injury remains responsible for continued or increased disability during employment with a later carrier, unless the claimant sustains a new injury or occupational disease during the subsequent employment. See Donald C. Moon, 43 Van Natta 2595 (1991); Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, SAIF, having accepted the 1987 low back injury claim, remains responsible unless claimant sustained a new compensable injury or occupational disease while working for UEI's insured. ORS 656.005(7)(a) and 656.802.

Whether claimant sustained a new injury or disease or an aggravation of his 1987 injury presents a complex medical question that requires expert medical opinion. Uris v. Compensation Department, 247 Or 420 (1967), Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). The

medical evidence indicates that claimant did not sustain a new compensable injury or occupational disease while UEI was on the risk.

Claimant's treating physician, Dr. Brett, a neurologist, opined that claimant's flare up of symptoms in June 1990 represented only a symptomatic aggravation of his preexisting low back condition. Dr. Brett also stated that claimant's July 1987 industrial injury was the major contributing cause of claimant's present condition and need for treatment.

Dr. Logan, an orthopedic surgeon with the Orthopaedic Consultants also examined claimant. Dr. Logan opined that claimant did not sustain a new injury, but his back condition was temporarily aggravated. Dr. Logan further stated that claimant's symptoms are chronic in nature and follow his July 1987 injury.

Dr. Phillips, chiropractor, opined that claimant's long-haul driving is a major contributing factor in claimant's need for treatment and lost time from work.

We find Drs. Brett and Logan more persuasive than Dr. Phillips. We generally give greater weight to the conclusions of a treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, we find no persuasive reason not to defer to claimant's current treating physician, Dr. Brett. Furthermore, Dr. Brett's opinion is supported by orthopedic surgeon, Dr. Logan. Accordingly, we conclude that claimant has failed to establish that he sustained a new injury while UEI was on the risk.

ORDER

The Referee's order dated March 15, 1991 is affirmed.

January 3, 1992 Cite as 44 Van Natta 3 (1992)

In the Matter of the Compensation of
ROBERT L. TRUMP, Claimant
WCB Case No. 90-18096
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's denial of reimbursement for thermography. On review, the issue is medical services. We vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

Claimant initiated this proceeding after receiving SAIF's partial denial of his thermography procedure. SAIF contends that claimant and his doctors violated OAR 436-10-040(10) by not requesting prior authorization of the thermography procedure. OAR 436-10-040(10) provides that liquid crystal thermography, photographic or electronic, is not reimbursable without prior authorization.

The rule also states that SAIF may require documentation to show why use of thermography is preferable to usual diagnostic tests and also provides that SAIF may limit the number of times it may be used in each case. The Referee upheld SAIF's denial of claimant's thermography citing this rule.

We recently held that under amended ORS 656.704(3) "matters concerning a claim" over which the Board, and thus the Hearings Division, has jurisdiction, do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. Stanley Meyers, 43 Van Natta 2643 (1991). ORS 656.327 provides a procedure for the resolution of disputes between a carrier and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services."

We conclude that this dispute involves medical treatment "in violation of the rules regarding the performance of medical services." Treatment in violation of the rules regarding the performance of medical services is no longer a matter concerning a claim over which the Hearings Division has jurisdiction. ORS 656.327; ORS 656.704(3). Because such disputes are no longer matters concerning a claim, original jurisdiction lies exclusively with the Director. Stanley Meyers, supra. Accordingly, we must vacate the Referee's order for lack of jurisdiction.

ORDER

The Referee's order dated January 14, 1991 is vacated.

In the Matter of the Compensation of
TODD S. ANDERSON, Claimant
WCB Case Nos. 90-09651, 89-26233, 90-09650 & 90-09649
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of those portions of Arbitrator Mongrain's order which: (1) set aside its denial of claimant's aggravation claim for a back condition; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for the same condition; (3) assessed a penalty for SAIF's allegedly unreasonable responsibility denial; and (4) awarded an assessed fee of $2,500 for claimant's counsel's services at hearing. In the alternative, SAIF argues that the assessed fee is excessive. On review, the issues are responsibility, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

Claimant's counsel actively and meaningfully participated in the arbitration proceeding.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We review the Arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989). Where an arbitrator's order is not consistent with applicable law, we remand for the proper application of law. See Yolanda Carrasco, 42 Van Natta 2289 (1990).

The Arbitrator in the present case concluded that the law, as amended by Oregon Laws 1990 (Special Session), Chapter 2., applied to this matter. The parties on review agree. Further, the Arbitrator found that claimant's current condition is properly analyzed as an occupational disease because it is not the unexpected result of a specific injurious incident but arose over a period of several days. The Arbitrator then proceeded to conclude that SAIF remained responsible for claimant's back condition because SAIF had not proven that claimant had sustained a new occupational disease while employed by Liberty Northwest's insured.

After conducting our review, we conclude that the Arbitrator's order is consistent with the applicable law. Accordingly, we affirm the Arbitrator on the issue of responsibility. See Donald C. Moon, 43 Van Natta 2679 (1991); Ricardo Vasquez, 43 Van Natta 1678 (1991).

Penalties and Attorney fees

The Arbitrator found that claimant was entitled to a penalty and claimant's attorney was entitled to one half the penalty in lieu of an attorney fee, for SAIF's unreasonable denial of responsibility. We agree with the Arbitrator that SAIF did not have a legitimate doubt, from a legal standpoint, as to its liability. Accordingly, we agree with the Arbitrator's conclusion that, based upon the medical evidence at the time of its denial, SAIF's denial was unreasonable. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). We, therefore, affirm the Arbitrator on the penalty issue.

Assessed Attorney Fee

The Referee awarded claimant's attorney an assessed fee of $2,500 for his services at hearing. ORS 656.307(5) authorizes an insurer-paid attorney fee if claimant's counsel actively and meaningfully participates in the arbitration proceeding. The proceeding commences upon the Board's receipt of a ".307" order. Therefore, fees may be assessed for services performed before hearing. Kenneth Cage, 43 Van Natta 1473 (1991).

SAIF concedes that claimant's counsel actively participated in a pre-hearing deposition. In that deposition, claimant took the position that SAIF was responsible. Additionally, at hearing, claimant brought out testimony that there had been no accidents or injuries during his subsequent employment with Liberty's insured. Upon our review, we conclude that claimant's attorney actively participated at hearing and asserted the prevailing view on the responsibility issue, i.e., that SAIF is responsible. Therefore, we conclude that claimant is entitled to an assessed fee. After considering the factors set forth in OAR 438-15-010(4), we modify the Arbitrator's award. We conclude that a reasonable assessed fee for claimant's attorney's services during the arbitration proceeding is $1,800. We particularly considered the time devoted to the case (as represented by the hearing record), and the risk that claimant's counsel's services might go uncompensated.

Claimant requests an attorney fee on review. A ".307" order issued prior to hearing and responsibility was the only issue litigated on review. However, claimant testified that Liberty had a lower rate of temporary disability compensation than SAIF. Accordingly, claimant's right to compensation was at risk of reduction, had SAIF's appeal been successful. Inasmuch as there was a risk that claimant's compensation would be reduced had we reversed the Arbitrator's order and found Liberty responsible, we conclude that claimant is entitled to an insurer paid attorney fee for services on review, to be paid by SAIF. See Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991); Ollie D. Wigger, 43 Van Natta 261 (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 responsibility issue is $750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Arbitrator's order is affirmed in part and modified in part. In lieu of the Referee's assessed attorney fee award, claimant's counsel is awarded a fee of $1,800 for services at hearing. For services on Board review, claimant's counsel is awarded an attorney fee of $750, to be paid by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
JACQUELINE ECKERT, Claimant
Own Motion No. 91-0683M
OWN MOTION ORDER
Olson, et al., Claimant Attorneys

The insurer submitted a claim for an alleged worsening of claimant's September 28, 1981 right thoracic outlet and left shoulder injury. Claimant's claim was first closed on February 11, 1982. The insurer accepted the compensability of a proposed left shoulder surgery and recommends that we authorize the payment of temporary disability compensation.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Here, the insurer reopened claimant's claim on July 9, 1985. This claim was closed by a September 1, 1988 Determination Order. However, that Determination Order was set aside as premature by an October 6, 1989 Opinion and Order. The insurer submitted a Determination Request to the Evaluation Section of the Department of Insurance and Finance on May 21, 1990 and again on July 6, 1990. However, there is no evidence that a Determination Order has issued or that the claim has been closed. We accordingly find that claimant's aggravation rights have not yet expired and and conclude that we lack jurisdiction under ORS 656.278(2). Because we lack jurisdiction to authorize own motion benefits, we deny claimant's request and instruct the insurer to process claimant's claim under ORS 656.262 and 656.273.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOE FERNANDEZ, JR., Claimant
WCB Case No. 90-18415
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Gracey & Davidson, Defense Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The alleged noncomplying employer requests review of Referee Myzak's order that set aside the SAIF Corporation's denial (on behalf of the noncomplying employer) of claimant's aggravation claim for his low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant established a compensable aggravation of his low back. We disagree.

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 22 (1989) rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

We agree with the Referee that claimant's condition has worsened and we adopt the Referee's Opinion and Conclusions on the issue of claimant's worsened condition. However, inasmuch as the July 12, 1990 mo-ped injury, which did not occur in the course and scope of claimant's employment, contributed to his worsened condition, he must also prove legal causation.

Generally, a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if there is an off-work injury which is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991).

Here, claimant's treating physician, Dr. Wright, M.D., reported on July 26, 1990, that claimant's "recent accident (by motorcycle) is likely the primary cause of the exacerbation of pain but he appears to have persistent root compression by his studies in November of 1988 and March of 1989."

On December 6, 1990, Dr. Wright concurred with a letter from claimant's counsel stating that, "although the bicycle accident would be considered a

significant factor in precipitating the exacerbation, it would not be considered as the major factor in the worsened condition."

In a January 9, 1991 deposition, Dr. Wright testified that he was unable to ascertain whether claimant's compensable injury was the major cause of his worsened condition. (Ex. 39-20). Dr. Wright testified that it was probable that the industrial injury was the major cause. (Ex. 39-20). However, Dr. Wright was referring to the major cause of claimant's underlying condition rather than his worsened condition. (Ex. 39-19). Moreover, Dr. Wright agreed with SAIF's counsel that it was probable that the motorcycle accident was the single incident that caused the worsening he saw on claimant's MRI. Tr. 20. Dr. Wright stated that it was probable "that the reason the MRI looks much worse is that he's had an aggravating injury." (Tr. 21).

Taken as a whole, we interpret Dr. Wright's opinion to mean that the major cause of claimant's worsened condition was the off-work mo-ped accident. Although Dr. Wright signed a concurrence letter contradicting his original opinion, we find the letter conclusory as there is no explanation for his change of opinion. Accordingly, we decline to rely upon the concurrence letter. Moreover, Dr. Wright's final statement on the subject of causation indicates that, as he originally stated, he believes that the mo-ped accident is the single incident which caused the worsening of claimant's low back condition, as evidenced by the MRI taken after the off-work accident.

Under the circumstances, we conclude that the July 12, 1990 mo-ped accident was the major contributing cause of claimant's worsened condition. Accordingly, claimant's worsened low back condition is not compensable.

ORDER

The Referee's order dated March 7, 1991 is reversed. The SAIF Corporation's denial (on behalf of the alleged noncomplying employer) is reinstated and upheld. The Referee's attorney fee award of $2,000 is also reversed.

In the Matter of the Compensation of
LORI KEEFAUVER, Claimant
WCB Case No. 90-04291
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of that portion of Referee Otto's order which set aside its partial denial of disability and/or treatment for claimant's preexisting spondylolisthesis and stenosis conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

The employer first asserts that the Board's actions on June 25, 1990, do not qualify as a convened hearing because no evidence was offered or admitted and the merits of the case were not discussed. According to the employer, therefore, this case is subject to the new law effective July 1, 1990, because this case actually was not litigated until the March 28, 1991 hearing.

In John K. French, 43 Van Natta 836, 838-39 (1991), we concluded that the Board has authority to reschedule or accelerate a hearing, provided that it gives proper notice under ORS 656.283(5), and then continues the hearing at a later date. The continuance was justified in those circumstances because the Board had scheduled a number of cases for that day in order to offset its failure initially to schedule a hearing within 90 days of claimant request and in light of the legislature's 1990 amendments to the workers' compensation statutes. Id.

The June 25, 1990 hearing took place and was continued under the same circumstances as those in French. We, therefore, conclude that the Referee correctly declined to apply the 1990 statutory amendments.

The Referee analyzed this case as a claim for an occupational disease under former ORS 656.802(1)(c), concluding that claimant proved that her compensable injury caused her preexisting back condition to become symptomatic.

We disagree that this case is appropriately analyzed under former 656.802(1)(c). Claimant is attempting to obtain compensation for the symptoms of her preexisting congenital back condition on the theory that her compensable injury caused her preexisting condition to become symptomatic and require medical services. In such cases, it is appropriate to examine the relationship between the injury and the preexisting condition. Scarratt v. H.A. Anderson Construction Co., 108 Or App 554, 558 (1991). Unlike former ORS 656.802, which requires a showing that the underlying condition has worsened, disabling symptoms of the underlying disease are compensable if they are caused by an occupational injury, even in the absence of a worsening of the underlying disease. See Barrett v. D & H Drywall, 300 Or 325, 300 (1985), clarified 300 Or 553 (1986). Moreover, symptoms that require medical services are compensable if they are caused by an occupational injury, even if the underlying disease has not worsened. Scarratt, supra, 108 Or App at 557-58.

We are persuaded that claimant has proven that her compensable injury caused her asymptomatic congenital back condition to become symptomatic and require medical services. Claimant was treated by several doctors for her low back condition. Although they agreed that claimant's symptoms were a result of her congenital condition, only Dr. Kitchel, claimant's treating orthopedic surgeon, directly addressed the causation of the symptoms. Dr. Kitchel stated several times that claimant's injury caused her preexisting condition to become symptomatic. (Exs. 21-1, 23-3, 23F, 26).

The employer urges us to rely on the report of the Western Medical Consultants, which states that claimant's preexisting spinal condition was unrelated to her occupational injury. (Ex. 24). Their opinion does not differ from the other doctors who saw claimant, including Dr. Kitchel, none of whom indicated that claimant's congenital condition was caused or worsened by the injury. As the Referee noted, however, the report from the Western Medical Consultants provides no explanation for the existence of claimant's symptoms. We find their report of little or no assistance. Instead, like the Referee, we defer to the opinion of Dr. Kitchel, claimant's treating physician, and conclude that

claimant has proven that the onset and continuation of symptoms of her preexisting condition were caused by her compensable injury.

The employer nevertheless argues that treatment directed to claimant's preexisting condition is compensable only if the compensable injury has pathologically worsened that condition. We do not agree. Under the applicable law, as long as ongoing symptoms of claimant's preexisting condition continue to be related to her compensable injury, treatment related to those symptoms is compensable. Scarratt, supra. Moreover, the fact that treatment of claimant's symptoms requires treatment of her noncompensable preexisting condition does not render such treatment itself noncompensable. See SAIF v. Roam, 109 Or App 169 (1991) (treatment of the noncompensable condition is compensable where it is a necessary prelude to treatment of the compensable injury).

We note parenthetically that, under the 1990 amendments to the workers' compensation law, treatment and disability resulting from the combination of claimant's compensable injury and her preexisting back conditions would be compensable only to the extent that her injury remained the major cause of the resulting condition. ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991).

Because the employer requested review and we have not disallowed or reduced claimant's compensation, claimant's counsel is entitled to an assessed attorney fee under 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 $900, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 24, 1991 is affirmed. For services on Board review, claimant's attorney is awarded $900, to be paid by the self-insured employer.

January 6, 1992 Cite as 44 Van Natta 10 (1992)

In the Matter of the Compensation of
LUIS A. LUGO, Claimant
WCB Case No. 90-18129
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Leahy's order that upheld the self-insured employer's denial of his bilateral median entrapment and bilateral carpal tunnel syndrome conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the fifth and tenth paragraphs in that section. We add the following supplementation.

On May 23, 1990, Steve Ross, claimant's supervisor, filled out an accident report in which he stated that claimant had experienced a problem with pain in his hand, wrists and arms for approximately two months. Ross reported the "accident cause" as continuous twisting of the wrist while driving a pallet jack or stand-up lift. He recommended rotating claimant to a different position.

In November 1990, claimant's condition was diagnosed as bilateral carpal tunnel syndrome by Dr. Baum, D.O.

Claimant was examined on one occasion by Dr. Nathan, an independent medical examiner. Claimant was also examined once by Dr. Baum.

CONCLUSIONS OF LAW AND OPINION

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

On review, claimant contends that the Referee erred in assigning greater weight to the opinion of Dr. Nathan, an independent medical examiner. Claimant argues that Dr. Nathan has not rebutted Dr. Baum's opinion that claimant's work activity caused his carpal tunnel syndrome.

We do not agree that the Referee erred in finding Dr. Nathan's opinion more persuasive. This case is sufficiently complex that causation must be established by expert medical opinion. Somers v. SAIF, 77 Or App 259, 262 (1986). We conclude that, as a hand surgeon, Dr. Nathan has more expertise in this field than Dr. Baum, an osteopathic physician. Additionally, we agree with the Referee that, in this case, there is no reason to give special deference to the opinion of a treating physician, because resolution involves expert analysis rather than expert external observation. See Allie v. SAIF, 79 Or App 284, 287 (1986). Finally, we agree with the Referee that, because Dr. Baum treated claimant upon one occasion only, there is no reason to defer to him as a treating physician.

ORDER

The Referee's order dated March 12, 1991 is affirmed.

In the Matter of the Compensation of
GEORGE A. FERGUSON, Claimant
WCB Case Nos. 90-13891 & 90-07687
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Seifert's order which: (1) affirmed a March 22, 1990 Determination Order which awarded no scheduled permanent partial disability, and (2) increased claimant's unscheduled permanent partial disability award for a shoulder injury from 30 percent (96 degrees), as awarded by a June 13, 1990 Determination Order, to 33 percent (105.6 degrees). On review, the issue is extent of scheduled and unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scheduled Disability

We adopt the conclusions and reasoning concerning the extent of scheduled permanent disability as set forth in the Referee's order.

Unscheduled Disability

Because claimant's condition became medically stationary on March 7, 1990, and her claim was closed by Determination Order on June 13, 1990, 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.

Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

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.

The parties do not dispute the Referee's values for age [1] and education [3]. The parties also do not dispute the impairment finding of 24 1/2 percent based on: lost ranges of motion in the shoulder; chronic condition pursuant to former OAR 436-35-320(4); resection of the clavicle and resection of the acromion pursuant to former OAR 436-35-330(14) and (15).

Adaptability

The Referee found that the adaptability factor was 2 under former OAR 436-35-310(3). Claimant argues that she is entitled to an adaptability factor of 4 pursuant to former OAR 436-35-310(4), because she argues she is not working as a result of her compensable right shoulder condition. Dr. McNeill released claimant to modified work in the light category with no repetitive lifting at or above shoulder level. Claimant returned to work in January 1990, but was unable to continue to perform the work. A worker is not considered to have left work as the result of the injury if a seasonal job ends or the worker is laid off. See Lorene E. Yost, 43 Van Natta 2321 (1991); Cleophas C. Chambliss, 43 Van Natta 904 (1991); Joyce M. Ramirez-Jones, 43 Van Natta 342 (1991). Here, however, claimant left her job because she could not perform the work. Under these circumstances, we agree that claimant is entitled to an adaptability factor of 4 pursuant to former OAR 436-35-310(4)(c).

Impairment

Claimant argues entitlement to an award of 12 percent for total shoulder arthroplasty (joint replacement) under former OAR 436-35-330(15). The record contains no evidence that claimant's operation involved a total shoulder joint replacement. We, therefore, do not make an award for total shoulder arthroplasty.

Claimant contends she is entitled to an award for loss of shoulder strength due to physical damage to the shoulder under former OAR 436-35-320(19). In support of her argument, claimant cites to findings in the Western Medical Consultants' report which was performed before claimant's shoulder surgery. Claimant's treating physician and surgeon, Dr. McNeill, is the only physician to examine claimant after her shoulder surgery when she was medically stationary with regard to her shoulder condition. Dr. McNeill opines that claimant's impairment of the shoulder is mild. Dr. McNeill also opines that there is no sensory, motor, reflex change or atrophy and that claimant's muscle strength is normal. Accordingly, we conclude that claimant has not proven entitlement to an award for loss of shoulder strength due to physical damage.

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 3, the sum is 4. When that value is multiplied by claimant's adaptability value 4, the product is 16. When that value is added to claimant's impairment value 24 1/2, the result is 40 1/2 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, 41 percent.

ORDER

The Referee's order dated March 12, 1991 is affirmed in part and modified in part. In addition to the Referee's and Determination Order award of 33 percent (105.6 degrees) unscheduled permanent disability, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent partial disability for a total award of 41 percent (131.2 degrees). Claimant's attorney shall receive 25 percent of the increased compensation created by this order. However, the total attorney fee awarded by the Referee and the Board Orders shall not exceed $3,800. The remainder of the order is affirmed.

January 7, 1992 Cite as 44 Van Natta 13 (1992)

In the Matter of the Compensation of
RODNEY H. GABEL, Claimant
WCB Case Nos. 90-01883 & 90-14619
ORDER ON RECONSIDERATION
Allen, Stortz, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys
Gary Wallmark (Saif), Defense Attorney

CNA Insurance Companies requests reconsideration of our December 11, 1991 Order on Review. In that order, we concluded that: (1) the tenosynovitis and carpal tunnel syndrome (CTS) conditions are compensable; (2) the SAIF Corporation is responsible for claimant's tenosynovitis condition; and (2) CNA is responsible for his recurrent CTS condition.

On reconsideration, relying on Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), CNA contends that SAIF is responsible for claimant's recurrent CTS condition because: (1) claimant's residual surgical scarring from CNA's accepted CTS claim was a predisposition; and (2) the tenosynovitis condition caused by subsequent work activities at SAIF's insured was the active contributor to the need for the second CTS surgery.

Spurgeon dealt solely with the issue of compensability of an occupational disease claim. Therefore, Spurgeon is inapposite to the issue of responsibility. In its request for reconsideration, CNA is not arguing that the recurrent CTS condition is not compensable. Furthermore, although Dr. Ellison noted a contribution from the tenosynovitis condition to the recurrent CTS and the need for the second CTS surgery, he maintained his opinion that the major contributing cause of both the recurrent CTS and the need for surgery was claimant's accepted injury with CNA, the first surgery, and the scar tissue from that first surgery. (Exs. 32, 39, 40-24, 40-25, 40-26, 40-27). We conclude that our Order on Review adequately addresses the medical evidence and the responsibility issue.

Accordingly, our December 11, 1991 is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 11, 1991 order in its entirety.

January 7, 1992 Cite as 44 Van Natta 14 (1992)

In the Matter of the Compensation of
STEVEN K. MILES, Claimant
WCB Case No. 88-17001
SECOND ORDER ON REMAND
Galton, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

On December 20, 1991, we abated our November 26, 1991 Order on Remand, which reversed the Referee's order and set aside the employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. We took this action to consider the self-insured employer's motion for reconsideration and to allow claimant an opportunity to submit his response.

Since our abatement order, we have received a copy of the parties' stipulation in WCB Case No. 91-12799, which resolved all issues raised or raisable between them that were pending before the Hearings Division. Pursuant to the stipulation, the employer agreed to withdraw its motion for reconsideration of our Order on Remand. The stipulation has received Referee approval.

In accordance with the stipulation, the employer has withdrawn its motion for reconsideration. Accordingly, as supplemented herein, we adhere to and republish our November 26, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

January 7, 1992 Cite as 44 Van Natta 14 (1992)

In the Matter of the Compensation of
LONNY D. MOORE, Claimant
WCB Case No. 90-15831
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of those portions of Referee Tenenbaum's order that: (1) increased claimant's unscheduled permanent

disability award for a low back and left hip injury from 5 percent (16 degrees), as awarded by Determination Order, to 17 percent (54.4 degrees); and (2) awarded a penalty-related attorney fee for an unreasonable resistance to the payment of compensation. In its brief, the employer contends that the Referee erred by admitting Exhibit 19-A into evidence. Claimant cross-requests review of that portion of the order that established February 1, 1987 as the date from which aggravation rights are to be computed. On review, the issues are evidence, extent of permanent disability, aggravation date, and penalty-related attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the "Findings" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Evidence

In its brief, the employer argues that the Referee admitted Exhibit 19-A over its objection that the document was not material to the current case and that it was not "supplied" to the employer. Exhibit 19-A is a copy of the notice regarding changes in the workers' compensation law provided by the SAIF Corporation to affected claimants, which claimant included in the packet of documents submitted to the employer on December 10, 1990, ten days before hearing. Since the document was "supplied" to the employer at this time, we read the term "supplied" as used in the brief to mean that the document was not timely disclosed. Failure to timely disclose documents may be considered grounds for their exclusion as evidence. OAR 438-07-015(5). However, at the hearing, the employer objected to the admission of the document solely on the ground that it was not material to the case before the Referee. Because the employer did not raise the issue of untimely disclosure at hearing, we do not address that issue on review. Theodore W. Lincicum, 40 Van Natta 1760 (1988).

Furthermore, the Referee has discretion to allow admission of additional documentary evidence into the record that had not been disclosed pursuant to OAR 438-07-015, provided there is no material prejudice to the other party that has resulted from the timing of the disclosure. OAR 438-07-018(4). This document falls into this category because it was procured by the direct efforts of claimant's attorney and was not disclosed until the hearing. Therefore, we review the Referee's exercise of such discretion only for abuse. As noted above, the employer's objection at hearing went only to the materiality, or weight, of the document. The employer did not contend that it was materially prejudiced by the timing of the receipt of the document. Accordingly, although the Referee made no specific finding, we infer from her acceptance of the document, and the employer's agreement that the objection would go to the weight of the document, that the Referee found no material prejudice from the timing of the disclosure. We consequently conclude that the Referee did not abuse her discretion in admitting the document.

Extent of Permanent Disability

We adopt the conclusions and reasoning concerning the issue of exent of unscheduled permanent disability as set forth in the Referee' s order.

Aggravation Date

We adopt the conclusions and reasoning concerning the aggravation date issue as set forth in the Referee's order.

Penalty-Related Attorney Fee

The Referee concluded that the notices sent to claimant by the employer regarding palliative medical services constituted unreasonable resistance to the payment of compensation. Therefore, she awarded a penalty-related attorney fee. We disagree.

The notices regarding palliative care, which were sent to claimant by the employer, were not in response to a claim for compensation. In fact, there were no outstanding medical billings at the time the employer sent the notices. Inasmuch as there was no claim for compensation, it follows that there could not be an unreasonable resistance to the payment of compensation. See Kathryn E. Lund, 43 Van Natta 312 (1991); Kathy J. Richard, 42 Van Natta 2030 (1990). Under these circumstances, claimant is not entitled to a penalty-related attorney fee pursuant to ORS 656.382(1). Ellis v. McCall Insulation, 308 Or App 74 (1989).

Attorney Fee/Board 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 is $750, 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 issues, and the value of the interest involved. We further note that claimant's attorney is not entitled to a fee for services devoted to the aggravation date, penalty, and attorney fee issues.

ORDER

The Referee's order dated January 11, 1991 is reversed in part and affirmed in part. That portion which awarded claimant's counsel a penalty-related attorney fee of $850 is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded a $750 assessed fee, payable by the self-insured employer.

In the Matter of the Compensation of
MICKEY L. PLATZ, Claimant
WCB Case No. 91-11623
INTERIM ORDER
Hollis Ransom, Claimant Attorney
Williams, et al., Defense Attorneys

Claimant has requested Board review of Referee Barber's November 26, 1991 "Interim Order of Remand." We have reviewed the request to determine whether we have authority to consider the matter. We conclude that jurisdiction rests with the Board.

FINDINGS OF FACT

On November 26, 1991, the Referee issued his Interim Order of Remand. Finding that a medical arbiter's report concerning claimant's impairment had not been considered by the Appellate Unit for the Evaluation Section of the Workers' Compensation Division, the Referee concluded that the Order on Reconsideration was invalid.

Consequently, the Referee set aside the Reconsideration Order and remanded the matter to the Appellate Unit for consideration of the medical arbiter's report. Reasoning that the interim order was not a final order, the Referee did not include a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On December 24, 1991, claimant mailed, by certified mail, to the Board her request for review of the Referee's November 26, 1991 order.

CONCLUSIONS OF LAW AND OPINION

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, if the Referee's order is correct, it is not a final appealable order because it does not finally determine the rights of the parties concerning claimant's hearing request from the Order on Reconsideration. Nevertheless, if the Referee's order is incorrect, the Referee's order will have finally determined the rights of the parties by dismissing the only request for hearing which would allow for litigation and modification of the Department's Reconsideration Order.

Inasmuch as claimant's entitlement to temporary and permanent disability is potentially impacted by the Referee's order, we conclude that it is an appealable final order. Because claimant timely requested Board review, the Referee's order has not become final. See ORS 656.289(3). Consequently, we hold that we have authority to consider the matters raised by claimant's request for Board review of that order.

A transcript of the oral proceedings has been ordered. Upon its receipt, copies will be distributed to the parties along with a briefing schedule. Thereafter, the case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation
GARY L. WALDRUPE, Claimant
WCB Case Nos. 90-17608 & 90-13576
ORDER OF ABATEMENT
Welch, et al., Claimant Attorneys
Roderick D. Peters (Saif), Defense Attorney
VavRosky, et al., Defense Attorneys

Claimant requests reconsideration of our December 13, 1991 Order on Review which held that the Hearings Division lacked jurisdiction to consider claimant's hearing request concerning the self-insured employer's denial of claimant's surgery claim. Relying on Tracy Johnson, 43 Van Natta 2546 (1991), we reasoned that since the denial was based on a contention that claimant had exceeded the number of attending physicians of his choice pursuant to ORS 656.254(3)(a), the Referee was without authority to address the dispute. Contending that the employer's denial also raised the issues of aggravation, as well as a causal relationship between the surgery and claimant's compensable injury, claimant asserts that the Referee was authorized to consider the matter.

Before addressing claimant's motion, we grant the employer an opportunity to respond. To be considered, the employer's response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

January 8, 1992 Cite as 44 Van Natta 18 (1992)

In the Matter of the Compensation of
LANCE M. KITE, Claimant
WCB Case No. 90-16586
ORDER ON REVIEW
Donald M. Hooton, Claimant Attorney
Snarskis, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of that portion of Referee Quillinan's order that set aside its denial of claimant's psychological condition. In its brief, the insurer also contends that the Referee should not have attributed 12 percent of claimant's total unscheduled permanent disability award to a "chronic pain" condition. Claimant cross-requests review of those portions of the Referee's order that: (1) found that he has a drug dependency condition; and (2) declined to rate unscheduled permanent partial disability of his psychological condition. In his brief, claimant contends that, if it is determined that he does have a drug dependency condition, it is related to the 1984 injury. On review, the issues are compensability and extent of unscheduled permanent partial disability. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

On August 8, 1984, claimant injured his right leg and right low back while working as a mill worker. The insurer accepted the resulting claim. Claimant's condition was found to be medically stationary on June 2, 1988. A Determination Order issued on June 30, 1988, awarding claimant 15 percent unscheduled permanent disability. By stipulation on October 27, 1988, claimant was awarded an additional 15 percent, bringing his total unscheduled permanent disability award to 30 percent.

Since an earlier injury to his back and neck in 1980, claimant suffers from chronic pain in his low back and right hip and leg. Claimant also has a history of severe headaches and diarrhea. Since the 1984 injury, claimant additionally suffers from groin pain.

Except for a short time in 1984, claimant has taken between one and three tablets of Tylenol # 3 every day since his injury in 1980. Tylenol # 3 contains the narcotic codeine, an addictive drug.

In June 1989, claimant's treating chiropractor, Dr. Buttler, referred claimant to Dr. Fleming, Ph.D., a clinical psychologist. Dr. Fleming diagnosed an adjustment reaction with considerable depression and anxiety. (Ex. 99). Dr. Fleming continued seeing claimant about twice a month until April 1990. After claimant's final visit to Dr. Fleming on June 25, 1990, Dr. Fleming declared claimant's psychological condition to be medically stationary. Additionally Dr. Fleming modified his diagnosis from adjustment reaction with depression to depressive neurosis.

Also in June 1990, claimant underwent an independent medical evaluation at the Western Medical Consultants. The psychiatric evaluation, conducted by Dr. Klecan, M.D., a psychiatrist, concluded that claimant had no psychiatric disorder related to his covered injury, but that he did present with an opiate dependence disorder. (Ex. 134).

A July 19, 1990 Determination Order awarded no additional permanent disability.

On December 12, 1990, the insurer denied claimant's mental disease or defect, concluding that claimant did not have a psychiatric disorder and, alternatively, that his compensable injury of August 8, 1984 was not the major contributing cause of his diagnosed condition of depressive neurosis or opiate dependence disorder.

Claimant was 36 years old at the time of the hearing. In June 1988, he participated in a vocational training program in computer-assisted drafting. Claimant successfully completed the program in 1990. He currently is employed by Bentley Engineering. Although full time work is available, claimant is limited by his pain to working six to six and one-half hours per day, five days a week.

CONCLUSIONS OF LAW AND OPINION

Compensability of Psychological Condition

The Referee found that claimant suffers from "a recognized diagnosed emotional disorder of depressive neurosis or dysthymic disorder," and that claimant's psychological condition "is compensably related to the 1984 industrial injury." (O & O at 8).

The Referee analyzed claimant's condition under ORS 656.802, as an occupational disease, and ORS 656.005(7)(a)(A), as a consequence of claimant's compensable 1984 injury. On review, the parties agree that the appropriate analysis for determining the compensability of the claim is under ORS 656.005(7)(a)(A). We also are persuaded that claimant's psychological condition should be analyzed as a "consequence" of the 1984 compensable injury. Claimant is not alleging that his mental condition arose out of the course and scope of his employment. Rather, he contends that his condition flows from the injuries sustained in the 1984 accident. We therefore review compensability under ORS 656.005(7)(a)(A). See Nordstrom, Inc. v. Gaul, 108 Or App 237 (1991); Julie K. Gasperino, 43 Van Natta 1151 (1991) (providing that a "consequence" normally relates to a claimant's condition which occurs as a result of the injuries sustained in an industrial accident, as distinguished from a condition directly arising from the industrial accident itself).

ORS 656.005(7)(a)(A) provides that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." The insurer asserts that claimant failed to prove that he suffers from a compensable mental disorder. The insurer further maintains that the evidence demonstrates that claimant only suffered from a drug dependency and that the 1984 injury was not the major contributing cause of his condition. We disagree.

The evidence here consists of the opinion of Dr. Fleming, who diagnosed claimant as suffering from depressive neurosis, and Dr. Klecan, who concluded that claimant did not suffer from any psychiatric disorder but did have an opiate dependence disorder. For the reasons that follow, we rely on Dr.

Fleming's opinion and conclude that claimant proved by a preponderance of evidence that he suffers from a mental disorder.

We find the opinion of Dr. Fleming, claimant's treating psychologist, to be more persuasive for several reasons. Claimant sought treatment from Dr. Fleming for nearly a year, seeing him about twice a week. Dr. Klecan, on the other hand, interviewed claimant for only two hours during one medical examination. We conclude that Dr. Fleming had a greater opportunity to observe claimant and become familiar with claimant's psychological condition than Dr. Klecan. Furthermore, Dr. Fleming's reports also included reasoning regarding the various factors causing claimant's mental state. For instance, Dr. Fleming's reports describe claimant's depression as being caused, in part, from worries about his "vocational future," "financial pressure" as well as his fear of "losing everything," including his home. (Exs. 106, 115). Dr. Klecan's report, on the other hand, contains nothing about claimant's vocational or financial concerns.

Dr. Fleming also found that the job injury was the major contributing cause of claimant's anxiety and depression. (Ex. 157). As noted above, Dr. Fleming clearly identified concerns with his vocational training and job future as causing claimant's psychological condition. Dr. Fleming also described claimant's mental state as being caused by his chronic pain. Dr. Fleming attributed these factors to the 1984 injury. See Ex. 99-5,6. We therefore conclude that claimant proved that the 1984 injury was the major contributing factor of his condition. See Paul W. Luhrs, 42 Van Natta 1312 (1990) (claimant's mental state due to concerns with vocational training and job future and therefore psychological condition was compensable); Rex A. Howard, 42 Van Natta 2010, 2014-15 (1990) (claimant's depression compensable because it resulted from chronic pain syndrome that was consequence of back problem).

Finally, the insurer argues that claimant's psychological condition is not subject to new aggravation rights because he has agreed that his mental condition is a "sequela" of the 1984 injury. We acknowledge that the compensability of claimant's psychological condition has been framed in terms of its relationship to claimant's compensable 1984 injury. Nevertheless, since the concern raised by the insurer is a claim processing issue arising out of this compensability determination, it would be inappropriate for us to consider it.

Compensability of Drug Dependency Condition

Claimant, on cross-review, challenges the Referee's finding that he was addicted to narcotics but, because he had been consuming the drugs since the 1980 injury, the drug dependency "was not worsened or materially affected by the 1984 injury." (O & O at 8). Claimant argues that the medical evidence did not prove that he suffers from such a condition. We agree.

Claimant does not dispute that he has consumed between 1 and 3 tablets of Tylenol # 3 per day since his injury in 1980. There was testimony by Dr. Klecan that the amount of pills and length of time claimant has taken the drug can lead to addiction. Dr. Klecan also testified that claimant shows several signs of dependency on the drug, including chronic pain, his descriptions of bouts with diarrhea, and his defensive attitude about his consumption.

However, we have found Dr. Klecan's opinion to be unpersuasive and we decline to rely upon his conclusion that claimant suffers from a drug dependency. Moreover, despite having been seen by numerous physicians, his chiropractor, Dr. Buttler, and his counselor, Dr. Fleming, Dr. Klecan was the only person to find a drug addiction. Although Dr. Buttler stated that he "agrees that claimant should discontinue Tylenol # 3 use" (Ex. 138), Dr. Fleming found it "desirable for [claimant] to get off pain medication" (Ex. 141), and Dr. Mitchell,

claimant's treating physician, "disagrees with this [claimant's] use of Tylenol # 3" (Ex. 148), in no case did any of them express the opinion that claimant had an addiction. Finally, Dr. Carvalho stated only that "it is suspected that [claimant] may have a [drug] dependency." (Ex. 133 at 7).

In short, we find that, although some of claimant's doctors expressed concern over his consumption of Tylenol # 3, they did not find a drug addiction. Accordingly, we conclude that there was insufficient proof of a drug dependency.

Because we have found that claimant does not have a drug dependency condition, we do not address his alternative argument that such a condition is compensably related to the 1984 injury.

Extent of Unscheduled Permanent Disability

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. We therefore agree with the Referee that former OAR 436-35-001 et seq. (WCD Admin. Order 7-1988) applies in rating claimant's permanent disability.

Low back condition

On review, the insurer contends that the Referee should not have attributed 12 percent of claimant's total 30 percent unscheduled permanent disability to a "chronic pain" condition. We agree. In the present case, claimant's total disability award consisted of a 1988 Determination Order award of 15 percent and a subsequent stipulated award of 15 percent unscheduled permanent disability. Because half of claimant's prior award was based upon an agreement between the parties, we do not adopt the Referee's reasoning that 12 percent of the total 30 percent award may be attributed to chronic pain.

Although the insurer disagrees with the Referee's reasoning on the issue of extent, it does not request a reduction of claimant's 30 percent award of unscheduled permanent disability for his low back condition. (Appellant's Reply Brief p. 3). Furthermore, claimant agrees that 30 percent adequately compensates him for his low back condition. Accordingly, we affirm the Referee on the issue of extent of unscheduled permanent impairment for claimant's low back.

Psychological condition

The Referee declined to determine the disability rating for claimant's mental condition, finding that the claim first had to be evaluated by the Department of Insurance and Finance. Both claimant and the insurer assert that, if we conclude that claimant's psychological condition is compensable, we should also proceed to rate his psychological condition.

When a claimant requests a hearing from a Determination Order and the Referee determines that claimant suffers from a compensable psychological condition, the Referee has the authority to determine all matters concerning the claim, including the extent of disability stemming from the compensable injury. Nellie M. Ledbetter, 43 Van Natta 570, 572 (1991). We also have no reason to believe that the Evaluation Section did not consider claimant's psychological condition. See id. The record regarding claimant's psychological condition was fully developed at hearing. We agree with the parties, therefore, that we may rate claimant's psychological condition at this time.

In regard to the impairment value for claimant's psychological condition, Dr. Fleming has opined that claimant's condition falls under former OAR 436-35-400(4)(b) Class 2: moderate (35-49%). The insurer disagrees with Dr. Fleming's impairment rating, arguing that claimant does not present with the kind of psychiatric disability which falls within the range of 35-49 percent additional permanent partial disability.

In order for a worker's mental condition to fall under former OAR 436-35-400(4)(b), a psychologist must note one or more of the various listed reactions, including thoughts of suicide. Here, Dr. Fleming not only noted claimant's occasional thoughts of suicide, but also documented claimant's nearly constant anxiety and frustration, as well as his difficulty in coping with vocational and financial concerns, chronic pain, and physical limitations. We therefore find that claimant successfully proved that his impairment rating for his psychological condition belongs under former OAR 436-35-400(4)(b). We further conclude that claimant is entitled to an impairment value of 35 percent for his mental condition. We find that claimant is entitled to the minimum value available under former OAR 436-35-400(4)(b) because, although experiencing a significant degree of depression, claimant has not shown that the degree of impairment caused by his psychological condition warrants a greater award. For instance, claimant successfully completed a retraining program and is able to work an average of 6 hours per day; claimant testified that he is unable to work full time due to his chronic pain rather than psychological factors.

In determining claimant's total unscheduled permanent impairment, we adopt the Referee's assigned vocational values; however, we conclude that, for purposes of rating disability, claimant's impairment value for his low back condition is 25 percent.[1]

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 of 51 percent (his combined low back impairment of 25 percent and psychological impairment of 35 percent, see former OAR 436-35-320(2)), the result is 56 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's total permanent disability under the "standards" to date is, therefore, 56 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 302, 390 (1987).

In this case, we find that claimant's award under the "standards" adequately reflects claimant's degree of permanent partial disability, including

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[1] We have above affirmed the Referee on the issue of extent of unscheduled permanent disability. Moreover, we have adopted the Referee's assigned "vocational" values under the standards. In order to determine claimant's impairment value for his low back condition, we therefore subtract the total "vocational" value of 5 (claimant's age (0), added to his educational value (2), multiplied by his adaptability value (2.5)), from the total award of 30 percent. Accordingly, we conclude that, for purposes of rating disability, claimant's impairment value for his low back is 25 percent.

disability caused by claimant's chronic pain condition. We therefore conclude that claimant failed to prove by clear and convincing evidence that his degree of permanent partial disability is greater than the award provided under the "standards."

Claimant is entitled to an assessed attorney fee for services on review concerning the issue of compensability of his psychological condition. See ORS 656.382(2). He is also entitled to an attorney fee for services at hearing and on review concerning his alleged drug dependency. 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 on Board review concerning the issue of compensability is $1,000 and a reasonable fee for services at hearing and on review regarding the drug dependency issue is $1,250, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the hearing record and claimant's respondent's brief), the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated January 16, 1991 is reversed in part, modified in part and affirmed in part. That portion of the Referee's order that found that claimant had a drug dependency condition is reversed. For services at hearing and on review concerning the drug dependency issue, claimant's attorney is awarded #1,250, to be paid by the insurer. That portion of the Referee's order that affirmed the July 19, 1990 Determination Order is modified. In addition to the prior Determination Order and stipulated awards of 30 percent (96 degrees), claimant is awarded 26 percent (83.2 degrees) unscheduled permanent disability for his low back and psychological conditions, for a total award to date of 56 percent (179.2 degrees) unscheduled permanent disability. 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 out-of-compensation attorney fee award shall not exceed $3,800. The remainder of the Referee's order is affirmed. For services on review concerning the issue of compensability of claimant's psychological condition, claimant's counsel is awarded a reasonable assessed fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
FRANK J. THORP, Claimant
WCB Case No. 89-14826
ORDER ON REMAND
Royce, et al., Claimant Attorneys
Larry D. Schucht (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. The court reversed our prior order, which found that claimant's work exposure was a material contributing cause of increased symptoms of his underlying back condition and therefore compensable under former ORS 656.802(1)(c). The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), which held that a claimant must establish that his employment was the major contributing cause of a claimed condition or its worsening in order to prove a claim for occupational disease under former ORS 656.802(1)(c).

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the 7th and 8th full paragraphs on page 3 of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's back injury and bilateral groin strain was compensable as an injury or an occupational disease. After finding that the case should be analyzed as an occupational disease, we affirmed. Relying on our first order in Donna E. Aschbacher, 41 Van Natta 1242 (1989), which held that a claimant could prove a compensable occupational disease claim under former ORS 656.802(1)(c) by merely showing that work was a material contributing cause of a claimed condition or a worsening of the symptoms of a preexisting disease, we concluded that the medical evidence proved that claimant's work was a material contributing cause of claimant's increased symptoms of his underlying back condition.

The Court of Appeals subsequently reversed our order in Aschbacher, holding that the legislature had not intended to change the standard of proof necessary to prove a claim under former ORS 656.802(1)(c) and that a claimant was still required to show that the work activity was the major contributing cause of a claimed condition or worsening of an underlying disease. Aetna Casualty Co. v. Aschbacher, supra. Relying on its holding in Aschbacher, the court has reversed our order and remanded this case for reconsideration.

We first republish that portion of our previous order which found that the claim appropriately is analyzed as an occupational disease and proceed to determine whether claimant satisfied his burden of proof under former ORS 656.802(1)(c). We turn to a determination of the compensability issue.

Claimant's treating physician, Dr. Butler, orthopedic surgeon, stated that claimant's work "did not independently worsen [his] condition. I believe his current condition is explainable based on his previous surgeries and a natural history of his ongoing back problem." (Ex. 41). In a subsequent opinion, Butler detailed claimant's back condition, stating that there was no "evidence of a disc injury" but that claimant did "have considerable degenerative changes at the facet joints at L-3, 4 bilaterally." (Ex. 43-1). In regards to the effect of claimant's work, Butler stated that "since [claimant] has returned to work at [SAIF's insured] in November 1987, he has had numerous stresses to his lower back." (Ex. 43-2). However, Butler found "no evidence objectively that * * * incidents [at work] produced any change in his back problems as measured by

tests. Clinically, however, he has had a great deal more pain, which has persisted[.] * * * He certainly had worsening of his symptoms[.]" (Id.) Butler added that claimant "has basically gone downhill over this (sic) last twelve months, in my opinion at a greater rate of speed than he would have if he had not been working at this particular job, but instead at a more sedentary type job. This worsening cannot really be measured by objective tests, and objectively I do not think we can state that he is worse, but subjectively he is certainly worse." (Id. at 2).

An independent examiner, Dr. Hazel, orthopedic surgeon, found that claimant "has multilevel degenerative intervertebral disc disease with a progressive degenerative process, the etiology of which is unknown and in his case might even be familial." (Ex. 27-2) Hazel further stated that, although an exacerbation of symptoms was preceded by an incident of stress to the back, his back pain was due to a "progression of his disease process, i.e., hypertrophic proliferation of tissues within the spine and interforaminal regions associated with superimposed stresses that render those additionally symptomatic." (Id. at 4).

In short, the medical evidence shows that claimant's employment conditions were not the major contributing cause of a worsening of claimant's underlying back condition. Claimant only demonstrated that his work produced his symptoms, which is not sufficient to satisfy former ORS 656.802(1)(c). See Aetna Casualty Co. v. Aschbacher, supra. We therefore conclude that claimant does not have a compensable occupational disease claim for his low back condition.

Accordingly, on reconsideration, the Referee's order dated May 24, 1990 is reversed. SAIF's denial is reinstated and upheld. The Referee's attorney fee award also is reversed.

IT IS SO ORDERED.

January 9, 1992 Cite as 44 Van Natta 25 (1992)

In the Matter of the Compensation of
MARIA ADAMSON, Claimant
Own Motion No. 91-0195M
OWN MOTION ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Employers Insurance of Wausau, Insurance Carrier

Claimant moves to supplement her request to reopen her claim for the payment of temporary disability compensation with a request for a penalty for the insurer's unreasonable delay of the payment of compensation. See ORS 656.262(10). She contends that the insurer failed to timely submit its recommendation to the Board. Because a December 11, 1991 Own Motion Order issued reopening claimant's claim, we treat her motion to supplement as a request for reconsideration.

The insurer is required to make a written recommendation to the Board within 90 days of receiving an own motion claim as to whether the claim should be reopened or denied. OAR 438-12-025 and 438-12-030. Here, the insurer received claimant's request for claim reopening on February 11, 1991. It timely submitted an April 10, 1991 Carrier's Own Motion Recommendation Form to the Board, recommending that claimant's request for reopening be denied on several grounds. The Board issued an order postponing action until a hearing had been held on the insurer's denial of surgery. Pursuant to the parties' stipulation at hearing, by a September 16, 1991 Settlement Order, the Referee set aside the

insurer's denial. In December 1991, the insurer issued a second Own Motion Recommendation Form, recommending to the Board that claimant's request for reopening be granted. Thereafter, the Board reopened the claim on December 11, 1991.

While the July 15, 1991 postponing order indicated that the parties "should" advise the Board of their positions on the reopening after the Referee's order, there is no requirement that the insurer submit another recommendation after an order or stipulation resolves related issues pending at hearing. The insurer timely discharged its obligation under our rules by submitting its initial recommendation. Accordingly, we do not find the insurer's conduct was unreasonable and decline to assess a penalty.

Our December 11, 1991 Own Motion Order is withdrawn. As supplemented above, we republish our December 11, 1991 Own Motion 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
HAROLD T. BIRD, Deceased, Claimant
WCB Case No. 90-18895
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Rosemary Bird, the widow of the deceased claimant, (hereafter referred to as claimant), requests review of Referee Otto's order which: (1) declined to order payment of death benefits pending appeal of an earlier referee's order; and (2) declined to assess penalties and fees for an allegedly unreasonable failure to pay the aforementioned benefits pending Board review of the earlier referee's order. On review, the issues are entitlement to death benefits pending appeal and penalties and fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's statement of the facts as stipulated by the parties.

CONCLUSIONS OF LAW AND OPINION

The Referee determined that this matter was separate and distinct from the earlier compensability determination, and is governed by amended ORS 656.313, which allows the compensation at issue to be stayed pending appeal of the earlier referee's order. We agree.

Claimant contends that the compensability of the deceased worker's claim, which was litigated prior to the effective date of Senate Bill 1197, is indistinguishable from the issue of her entitlement to death benefits, which was litigated after Senate Bill 1197 took effect. Therefore, she contends that her entitlement to death benefits should be determined by former ORS 656.313 which provided that compensation could not be stayed pending appeal.

Prior to July 1, 1990, ORS 656.313 provided that "[f]iling by an employer or the insurer of a request for review or court appeal shall not stay payment of

compensation to a claimant." The legislature, however, amended ORS 656.313 effective July 1, 1990. As amended, ORS 656.313 states that the filing of such a request or appeal stays the payment of compensation appealed except for: (1) temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs, and (2) permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed. ORS 656.313(1)(a), (A), (B).

Subsequent to the date of the Referee's order, we issued our opinion in Raymond J. Seebach, 43 Van Natta 2687 (1991). In Seebach, we held that although substantive compensability was litigated under the law in effect before July 1, 1990, the question of whether payment of compensation was stayed pending the insurer's appeal to this Board was a separate procedural "matter" which did not arise until after the issuance of the earlier referee's compensability determination. Therefore, we concluded that amended ORS 656.313, which allows compensation to be stayed pending appeal applied.

Likewise, in the present case, the question of whether payment of death benefits is stayed pending the appeal is a separate "matter" which arose (i.e., became at issue) after the earlier compensability determination. Inasmuch as claimant's hearing request regarding this matter was not filed before May 1, 1990 and hearing regarding this matter was not convened prior to July 1, 1990, the matter involved here was not "in litigation" for the purposes of section 54(2). See Raymond J. Seebach, supra. Therefore, this case was properly analyzed by the Referee under amended ORS 656.313.

Since we have concluded that the insurer was entitled to stay payment of the aforementioned compensation, it follows that the insurer's failure to pay these benefits was not unreasonable. Therefore, we assess no penalty.

ORDER

The Referee's order dated April 8, 1991 is affirmed.

January 9, 1992 Cite as 44 Van Natta 27 (1992)

In the Matter of the Compensation of
JERRY A. DOVE, Claimant
WCB Case No. 90-22034
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

The insurer requests review of Referee Menashe's order that directed it to pay additional temporary disability compensation. On review, the issue is claims processing. We reverse.

FINDINGS OF FACT

By Opinion and Order dated November 7, 1990, a prior Referee found that claimant sustained an aggravation of his compensable injury, and remanded the aggravation claim to the insurer for "processing consistent with Oregon Workers' Compensation Law." The insurer filed a request for Board review on November 13, 1990. The insurer has not paid temporary disability compensation for any period before November 7, 1990.

Claimant's hearing request concerning the insurer's refusal to pay compensation pursuant to the prior Referee's order was filed after May 1, 1990. A hearing was not convened before July 1, 1990.

CONCLUSIONS OF LAW AND OPINION

Applying former ORS 656.313, which was in effect before the 1990 amendments Oregon Laws 1990 (Special Session), chapter 2, the Referee concluded that the insurer's filing of a request for Board review did not stay the payment of any temporary disability compensation ordered payable by the November 7, 1990 Opinion and Order. We disagree.

ORS 656.313 governs the payment of compensation pending an appeal. Its former version, which the Referee applied, provided in relevant part that the "[f]iling by an employer or the insurer of a request for review * * * shall not stay payment of compensation to a claimant." The legislature amended the statute in 1990, and it now provides in relevant part:

> "(1)(a) Filing by an employer or the insurer of * * * a request for board review * * * stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs."

In determining that former ORS 656.313 applies, the Referee concluded that this matter was governed by the savings clause in subsection 54(2) of the 1990 Oregon Laws (Special Session), chapter 2. That subsection provides:

> "Any matter regarding a claim which is in litigation before the Hearings Division, the board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990."

The Referee reasoned that, because the prior hearing on the aggravation claim was requested before May 1, 1990, and convened before July 1, 1990, the insurer's obligation to pay compensation pending Board review was governed by the law in effect before July 1, 1990. We recently rejected that reasoning.

In Raymond J. Seebach, 43 Van Natta 2687 (1991), we concluded that the insurer's obligation to pay compensation pending Board review is a separate procedural matter from the substantive determination giving rise to that obligation. Therefore, inasmuch as claimant's hearing request concerning the insurer's refusal to pay compensation was not filed before May 1, 1990, and the hearing on that matter was not convened before July 1, 1990, we held that subsection 54(2) of the 1990 amendments does not apply and that the insurer's payment obligations are governed by amended ORS 656.313. Id.

As in Seebach, this claimant's hearing request concerning the insurer's refusal to pay compensation was not filed before May 1, 1990, and a hearing was not convened before July 1, 1990. Accordingly, amended ORS 656.313 applies here as well.

Under ORS 656.313(1)(a)(A), the payment of temporary disability compensation is stayed pending Board review, except for temporary disability

compensation that accrues from the date of the order appealed from. Accordingly, pending Board review, the insurer was not required to pay temporary disability compensation for any period before the November 7, 1990 Opinion and Order.

ORDER

The Referee's order dated April 5, 1991 is reversed. The order directing the insurer to pay temporary disability compensation for the period from January 15, 1990 to November 7, 1990 pending Board review of the prior Referee's order, as well as the approved attorney fee award, is reversed.

Board Member Tenenbaum specially concurring.

For the reasons stated in my dissent to Seebach, I maintain that the enforcement of the insurer's claim processing obligation should not be divorced from the compensability of the claim, for the purpose of applying section 54(2) of the 1990 Act. However, I am bound by that decision and reluctantly concur.

January 9, 1992 Cite as 44 Van Natta 29 (1992)

In the Matter of the Compensation of
VINCENT A. LOPEZ, Claimant
WCB Case No. 90-20485
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee Peterson's order which: (1) upheld the insurer's denial of claimant's right wrist injury claim; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant is 22 years of age. He began working for the employer as a machine operator in January 1990.

In July 1990, claimant was working the graveyard shift, 11:00 P.M. to 7:00 A.M. He was scheduled to work that shift on Friday, July 26, 1990 (shift ending Saturday, 7:00 A.M.). However, on or around July 20, he asked his supervisor for permission to take the next Friday off, because a cousin was coming to visit from California. Claimant was instructed to submit a written request as required by company policy.

Claimant failed to submit a written request. Instead, he approached his supervisor at the start of the shift on July 26, and asked to have the shift off. His supervisor denied the request because claimant had not made the request in writing as instructed. Claimant walked away in a huff. Approximately ten minutes later, claimant reported that he had injured his right wrist while using a tape gun, and was in severe pain.

Claimant left work shortly after reporting the alleged incident and went to a hospital emergency room. He was seen by Robert Fields, M.D., who diagnosed a sprain of the right wrist, traumatic carpal tunnel syndrome. Dr. Fields placed the right wrist in a splint, prescribed Advil for pain, and released claimant to light duty for four days.

During the ensuing weeks, claimant continued to report to Dr. Fields that he was in severe pain, and unable to return to work. Not being a hand and wrist specialist, Dr. Fields referred claimant for further treatment, to Dr. David LaGasse, an orthopedic and fracture surgeon. Claimant was first seen by LaGasse on August 23, 1990. At the examination, claimant complained that his pain was getting worse. However, the results of Dr. LaGasse's examination, including the X-rays, were normal in all respects, except claimant reported some tenderness in his wrist and hand. Thus, claimant had full range of motion of the fingers and wrist, good wrist strength and "no weakness." Because of these positive findings, Dr. Lagasse's report notes that "It is hard to say what has happened here." (Ex. 11)

Claimant was examined again by Dr. Lagasse on August 29, 1990. Although the examination results were normal, claimant continued to complain of unabated pain, now with some numbness in the small finger and the distal half of the ring finger. Therefore, Dr. LaGasse referred claimant to Dr. William Platt, neurologist, for an ulnar nerve evaluation, and to Dr. Samuel Gill, a hand specialist, for a second opinion. (Ex. 11)

Upon examination by Dr. Platt, claimant demonstrated a full range of motion of his wrists and hands and no swelling was evident. The nerve conduction studies were also normal. Dr. Platt reported that there were "no clear cut findings of nerve entrapment, either by examination or nerve conduction studies." (Ex. 15-2)

Dr. Gill's findings, upon examination, were also essentially normal, although claimant reported a spontaneous recurrence of pain which Gill described as "rather nondescript in nature." Dr. Gill's impression was muscle pain of undetermined etiology, with possible but doubtful ulnar nerve entrapment, left. However, Gill also reported that "I am really at a loss to actually explain this man's symptoms. The objective findings of any significant abnormality are minimal but he does seem reasonably believable. *** I must say that at this time I have no specific recommendations for any management, unless the electromygraph shows something, which I don't anticipate." (Ex. 21-1,2). The electrical studies suggested by Dr. Gill were ultimately done. They revealed no abnormalities.

Claimant returned to Dr. LaGasse on October 16, 1990, reporting what Dr. LaGasse characterized as "a different set of symptoms:" pain now extending from the inner side of the elbow down to the ulnar (outside) aspect of forearm into his hand. (Ex. 28)

In his last report, Dr. Lagasse observed that "An objective diagnosis of pathology has never been made," and that "I realize this is a vague and nebulous situation, but that is the nature of this case." (Ex. 32). Dr. Gill ultimately opined that claimant's complaints of pain were not compatible with any type of ulnar nerve injury and that claimant's subjective complaints did not correlate with any objective findings. (Ex. 32A).

FINDINGS OF ULTIMATE FACT

The occurrence of an accidental injury on July 26, 1990 arising out of and in the course of claimant's employment requiring medical services or resulting in disability was not established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW

Claimant had the burden of proving by a preponderance of the evidence, that he suffered a compensable injury. Hutcheson v. Weyerhaeuser, 288 Or 51

(1979). The Referee concluded that claimant failed to carry his burden. We agree.

As amended by Oregon Laws 1990 (Special Session), Ch. 2, Section 3, ORS 656.005 (7)(a) provides:

> "A 'compensable injury' is an accidental injury, *** arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings ***."

"Objective findings" in support of medical evidence are defined to include, but are not limited to, "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." Amended ORS 656.005(19). In Suzanne Robertson, 43 Van Natta 1505 (1991), we construed that statutory definition to require a determination by a physician, based on an examination of the injured worker, that the worker has a disability or need for medical services. Such a finding may be based on a physician's evaluation of the worker's description of the pain that he is experiencing. Jacqualyn L. Hetrick, 43 Van Natta 2357 (1991).

Here, Dr. Fields diagnosed a right wrist strain/sprain, based on his evaluation of complainant's description of the pain that claimant was experiencing. His medical reports would constitute medical evidence supported by objective findings, were those reports given substantial weight. We do not, however, find Dr. Fields' reports persuasive.

Although claimant was initially seen by Dr. Fields, he was referred by Fields for treatment to Dr. LaGasse, due to claimant's complaints of unabated pain and Dr. LaGasse's greater expertise in the field of medicine involved. Upon his examinations, LaGasse could find nothing wrong with claimant to explain his complaints of severe pain. LaGasse referred claimant to Dr. Platt, a hand and wrist specialist, for further tests, and to Dr. Gill for a second opinion. The results of the additional tests conducted by Dr. Platt were normal. Ultimately, LaGasse would characterize the situation as "vague and nebulous." Dr. Gill, based on his examinations, was "at a loss" to explain claimant's complaints of pain. He ultimately concluded that claimant's complaints were not compatible with any type of ulnar nerve injury and that claimant's subjective complaints did not correlate with any objective findings.

Claimant claims to have suffered an unwitnessed injury under what can only be described as suspicious circumstances. Claimant had the burden of proving that a compensable injury occurred. Dr. Fields' diagnosis of a right wrist sprain/strain does not explain the nature, severity, or duration of claimant's subjective symptoms, and the doctors to whom claimant was referred for treatment could find no objective medical basis for them. Under these circumstances, we do not find Dr. Fields' conclusory reports persuasive. On the basis of the record as a whole, we agree with the Referee that claimant has failed to carry his burden of proving that a compensable injury occurred.

Furthermore, we conclude that claimant is not entitled to a penalty or associated attorney fee. The insurer's denial was not unreasonable, as it was issued based on medical reports which provided a legitimate basis for doubting the compensability of the claim. Brown v. Argonaut Ins. Co., 93 Or App 588 (1988). In any event, we have found the claim not compensable. Consequently, there were no amounts "then due" upon which to base a penalty award. Lloyd L.

Cripe, 41 Van Natta 1774 (1989). Similarly, there has been no unreasonable resistance to the payment of compensation. ORS 656.382(1).

ORDER

The Referee's order dated February 20, 1991 is affirmed.

January 9, 1992 Cite as 44 Van Natta 32 (1992)

In the Matter of the Compensation of
JESUS MEJIA, Claimant
WCB Case No. 90-15042
ORDER ON REVIEW
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant, pro se, requests review of Referee Brown's order that: (1) increased his scheduled permanent disability award for the loss of use or function of the right forearm, from 24 percent (36 degrees) as awarded by the July 9, 1990 Determination Order, to 35 percent (52.5 degrees); and (2) affirmed the Determination Order award of 16 percent (51.2 degrees) unscheduled permanent disability for claimant's right shoulder condition. On review, the issue is extent of permanent partial disability, scheduled and unscheduled. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings," with the following exceptions and supplementation.

We do not adopt the Referee's finding that claimant has weakness and atrophy in his right thumb, which causes decreased grip strength in the right hand.

Claimant was not medically stationary and his condition was still improving at the time of Dr. Shames' November 1989 letter, which described claimant's loss of grip strength.

The Referee found that claimant's highest SVP (specific vocational preparation time) during the ten years prior to evaluation is 2, based on D.O.T. (Dictionary of Occupational Titles) #403.863-010. Instead, we find that claimant's job which had the highest SVP during the relevant time period is best described by D.O.T. #403.687-010 (Farmworker, Fruit II), which also has an SVP of 2.

CONCLUSIONS OF LAW AND OPINION

Scheduled disability

We adopt the Referee's "Opinion" concerning claimant's scheduled permanent disability, with the following exceptions and supplementation.

The Referee found claimant to be entitled to a 10 percent rating for lost grip strength in his right hand, caused by weakness and atrophy in the right thumb. In so doing, the Referee relied on a November 1989 letter from Dr. Shames, then treating physician, who noted reduced thenar muscle mass on the right and decreased grip strength on the right. (Ex. 20). However, claimant was not medically stationary at the time of Shames' report and there is no medical evidence of lost grip strength after claimant's condition became stationary

on April 5, 1990. On this evidence, claimant has not established permanent disability due to lost grip strength.

Consequently, claimant is entitled to ratings of 49 percent for fusion at 10 degrees (based on the surgical fusion of the metacarpophalangeal thumb joint) and 39 percent for 10 degrees retained motion in the distal interphalangeal joint. These values are combined for a total of 69 percent scheduled permanent disability for loss of use or function of the right thumb. Former OAR 436-35-050(6).

We have determined that claimant is entitled to less scheduled permanent disability compensation than he has been awarded previously. However, because the insurer has not requested a reduction in the amount awarded by the Referee, we do not disturb that award. See Robin M. Glover, 42 Van Natta 1081, 1082 (1990); see also Daniel M. Alire, 41 Van Natta 752, 759 (1989).

Unscheduled disability

We adopt the portion of the Referee's Opinion concerning claimant's unscheduled permanent partial disability.

ORDER

The Referee's order dated December 17, 1990 is affirmed.

January 9, 1992 Cite as 44 Van Natta 33 (1992)

In the Matter of the Compensation of
MELVIN O. ROBERTS, Claimant
WCB Case No. 91-00810
ORDER ON RECONSIDERATION
Galton, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Claimant requests reconsideration of our December 26, 1991 Order on Review. In that order, we upheld the insurer's partial denial of claimant's degenerative disc condition and need for medical services, declined to assess a penalty and attorney fee for an allegedly unreasonable denial, and found that the Referee did not err in admitting Exhibit 19 into the record.

On reconsideration, claimant argues that our evidentiary ruling is contrary to our decision in Harold T. Bird, 43 Van Natta 1732 (1991). In Bird, we held that ORS 656.283(7), should not be read to authorize admission of documents that are neither admissible under ORS 656.310(2) nor under the Oregon Evidence Code. ORS 656.283(7) provides that substantial justice is the sole guide to deciding evidentiary disputes "except as otherwise provided in this section and in rules of procedure established by the board. . . ."

Claimant's argument assumes that Exhibit 19 is inadmissible under ORS 656.310(2). We clarify our holding. ORS 656.310(2) provides an exception to the hearsay rule for medical, surgical and hospital reports presented by claimants, self-insured employers and insurers, provided that the doctor rendering the medical or surgical report consents to submit to cross-examination.

Exhibit 19 is a letter prepared by the insurer's counsel, sent to Dr. Wilson, signed by the doctor and faxed back to the insurer's counsel's office. The Referee admitted this document into the record subject to claimant's right to cross-examine the doctor. Claimant's counsel declined the opportunity to

cross-examine Dr. Wilson. Dr. Wilson signed the document indicating that it accurately reflected his medical opinion. Moreover, space was provided for the doctor to supplement the report or to indicate his disagreement with the document.

We, therefore, conclude that this document is a medical report and is admissible under ORS 656.310(2). Inasmuch as we find this document is admissible under ORS 656.310(2), we conclude that our Order on Review is not contrary to our holding in Harold T. Bird, supra.

Accordingly, our December 26, 1991 Order on Review is withdrawn. As supplemented and clarified herein, we republish our December 26, 1991 Order on Review 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
CATHIE J. YOUNG, Claimant
WCB Case No. 90-20781
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
William Brickey (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Bethlahmy's order which: (1) found that her low back injury claim had not been prematurely closed; and (2) affirmed a Notice of Closure that did not award any permanent disability. On review, the issues are premature closure and extent of scheduled permanent disability.

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

The Referee concluded that claimant's claim was not prematurely closed by the October 4, 1990 Notice of Closure. We agree.

On June 7, 1990, Dr. Beeson, chiropractor, expressly found that claimant's original injury had healed and merely recommended palliative care to alleviate claimant's residual symptoms. (Ex. 8). There is no medical report to the contrary. Accordingly, we find that claimant was medically stationary as of the October 4, 1990 Notice of Closure. See Linda F. Wright, 42 Van Natta 2570, 2571 (1990); Tommy L. Brown, 42 Van Natta 558, 560 (1990).

The Referee also concluded that claimant was not entitled to a permanent disability award for her chronic condition. We agree.

Where claimant fails to establish any measurable impairment resulting from her compensable injury, no award of disability is allowed. Former OAR 436-35-010(2)(b); OAR 436-35-280(1). Here, claimant has failed to establish a measurable impairment resulting from her compensable injury, as defined by the "standards." The "standards" define "impairment" as a decrease in function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the rating of permanent impairment, 2nd Edition, Copyright 1984. Former OAR 436-35-005(1). Dr. Beeson has released claimant to return to her regular work. Moreover, Beeson has concluded that

claimant's injury has healed. This conclusion is also shared by the Rehabilitation Center which found that claimant had not sustained permanent impairment as a result of her injury. In light of this medical evidence, claimant's testimony is not sufficient to entitle her to an award of permanent disability under the "standards." See William K. Nesvold, 43 Van Natta 2767 (1991). Therefore, we find that claimant has failed to establish entitlement to an award of permanent disability.

ORDER

The Referee's order dated February 28, 1991 is affirmed.

January 10, 1992 Cite as 44 Van Natta 35 (1992)

In the Matter of the Compensation of
VICKI S. BURNS, Claimant
WCB Case No. 90-20776
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

The insurer requests review of that portion of Referee Galton's order that set aside its denial of claimant's injury claim for a herniated disc at L4-5. On review, the issue is compensability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following modification.

Claimant's work activities on July 27, 1990, rather than July 23, 1990, were the major contributing cause of her disc herniation.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and opinion with the following supplementation and jurisdiction.

The Referee set aside the insurer's November 2, 1990 denial of claimant's back injury claim and "affirmed as moot" the March 4, 1991 denial, which clarified and supplemented the November denial by denying claimant's occupational disease claim for the same back condition.

We agree with the Referee's determination that this matter is properly analyzed as an injury claim. Here, as in Valtinson v. SAIF, 56 Or App 184 (1982), the injury was "unexpected," in that claimant was symptom free for some time prior to the sudden onset of pain. She had recovered from her March 1990 fall from the bandstand, and that incident is a "red herring" in this situation. As in Valtinson, the onset of symptoms was "sudden," in that it occurred in only a matter of hours. See Valtinson, supra at 188. For these reasons, as well as those set forth by the Referee, we conclude that claimant has proven that she sustained a compensable on-the-job injury on July 27, 1990.[1]

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[1] We note that the November 1990 denial referred not to the March 1990 bandstand injury, which caused no time loss and for which claimant sought no treatment. The parties did, however, also litigate the issue of an injury on July 27, 1990 and we, like the Referee, consider the denial to include that claim as well.

Although Dr. Mason, treating physician, noted risks associated with waitressing generally, he related claimant's herniated disc specifically to her work activities on July 27, 1990. (See Exs. 22-13, 22-24, 22-31, 22-35). Because there is no evidence that claimant's work activities, except those on July 27, 1990, caused her disc herniation, we conclude that she has not proven that she suffers from an occupational disease. Consequently, we uphold the insurer's denial of claimant's occupational disease claim.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. 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 attorney's services on review concerning the compensability issue is $400, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated March 28, 1991 is modified in part and affirmed in part. That portion of the order that "affirmed as moot" the insurer's March 4, 1991 denial of claimant's occupational disease claim is modified so that the insurer's denial is upheld. Claimant's attorney is awarded a reasonable assessed fee of $400, for his services on review, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ROSALIE S. DREWS, Claimant
WCB Case Nos. 90-05597 & 90-15186
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney
David O. Horne, Defense Attorney

Reviewed by the Board en banc.

Wausau Insurance Companies requests review of those portions of Referee Black's order that: (1) set aside its denial of claimant's aggravation claim for a low back injury; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. In her brief, claimant requests review of that portion of the Referee's order which allegedly did not find claimant's low back condition compensable. In the alternative, claimant moves for remand to the Hearings Division for further proceedings. On review, the issues are responsibility, compensability, and remand. We deny the motion to remand, and reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" as supplemented.

Wausau accepted a 1985 injury claim on an "801" claim processing form. The "801" form listed the body part affected as "low back left leg." The nature of the injury was described as "sprain, strain of low back, herniated."

On December 26, 1989, claimant tripped and fell over a desk drawer while at SAIF's insured, resulting in disability and the need for medical treatment involving the low back and left leg.

ULTIMATE FINDINGS OF FACT

The 1989 low back injury is a material contributing cause of claimant's disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant contends that the Referee made no findings regarding the compensability of her low back condition, and requests that the Board address this issue on review. In the alternative, claimant moves for remand to the Hearings Division for further proceedings on this issue. We consider the motion for remand first.

If the Board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee, it may remand the case to the referee for further evidence taking, correction or other necessary action. ORS 656.295(5). Here, the compensability issue was raised, developed, and litigated at hearing. The Referee's order addressed the compensability issue in the context of the responsibility discussion. He found the claim compensable as an aggravation and assigned responsibility to Wausau. Therefore, we conclude that remand is not appropriate. The request for remand is denied, and we proceed to consider the merits.

Compensability/Responsibility

The Referee decided this matter under the Workers' Compensation Act, as amended in 1990. On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Act. Or Laws 1990 (Special Session), ch. 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

As relevant, the amended law provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer." Or Laws 1990 (Special Session), ch. 2, 49(1).

We have interpreted the amended law to mean that, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991). Therefore, Wausau, as the last carrier against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, Wausau has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for SAIF's insured.

In order to prove a new compensable injury, Wausau must show that the 1989 injury is a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a); 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

On December 26, 1989, while working for SAIF's insured, claimant tripped and fell over an open desk drawer. As a result of this discrete accident, claimant injured her low back. Her treating physician, Dr. Nagel, reported that the injury resulted in reduced range of motion and slightly more prominent disc bulging at L4-5. Dr. Nagel also concluded that claimant's current symptoms were due to the recent injury. Moreover, claimant sought treatment in February 1990 for the effects of the 1989 incident. Therefore, we conclude that the medical record, supported by objective findings, establishes that claimant sustained an accidental injury in 1989 that was a material contributing cause of a need for treatment. See ORS 656.005(7)(a). Accordingly, Wausau has carried its burden of proving the occurrence of a new compensable injury involving the same condition, and responsibility for "all further compensable medical services and disability involving the same condition" shall be the responsibility of SAIF.

SAIF suggests a different analysis. SAIF asserts that, for purposes of determining whether claimant sustained a "new compensable injury" under the amended responsibility law, we must apply ORS 656.005(7)(a)(B). That statute provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or 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." Or Laws 1990 (Special Session), ch. 2, 3.

SAIF argues that the 1985 injury amounts to a "preexisting condition" for purposes of ORS 656.005(7)(a)(B). In addition, SAIF contends that claimant's 1989 injury while employed by its insured has combined with the preexisting condition from the 1985 injury, resulting in claimant's current condition. Therefore, SAIF asserts claimant did not experience a "new compensable injury" under the amended responsibility law unless the 1989 injury is the major contributing cause of the resulting condition. We disagree.

We do not find ORS 656.005(7)(a)(B) applicable in the responsibility context. We have recently held that ORS 656.005(7)(a)(B) does not determine compensability of the initial injury, but rather limits a carrier's liability for continuing disability or need for medical services. Bahman M. Nazari, 43 Van Natta 2368 (1991). Only after initial compensability has been favorably decided do we inquire, pursuant to ORS 656.005(7)(a)(B), whether the compensable injury has combined with a preexisting disease or condition. Thus, compensability of further disability or need for treatment is a separate issue, the resolution of which is not relevant to the assignment of responsibility question.

Accordingly, it is not Wausau's burden to establish that the 1989 injury was the major contributing cause of claimant's condition. Wausau's burden went no further than proving material contributing cause in order to establish a new compensable injury. Wausau has carried its burden of proof and responsibility for the claim shifts to SAIF. SAIF must accept responsibility for the claim and process it.

Claimant is entitled to an assessed fee for services on review concerning the issue of compensability. After considering claimant's statement of

services, as well as 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 Board review. 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.

ORDER

The Referee's order dated December 21, 1990 is reversed. Wausau's denial is reinstated and upheld. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. The Referee's attorney fee award shall be paid by SAIF, rather than Wausau. For services on Board review, claimant's attorney is awarded an assessed fee of $700, to be paid by SAIF.

Board Member Kinsley specially concurring.

I write to emphasize that it is always the claimant, not the insurer, that has the burden to prove a new, compensable injury:

> "The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker." ORS 656.266.

An insurer has the option to produce evidence to support its position on either side of a dispute involving section 49 of Oregon Laws 1990, chapter 2.

In the Matter of the Compensation of
JENNIFER MATTHIES, Claimant
WCB Case No. 90-16309
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Crumme's order which: (1) found that claimant was not entitled to temporary disability after September 12, 1989 because claimant had withdrawn from the work force; and (2) allowed the SAIF Corporation to offset temporary disability paid between September 12, 1989 through February 15, 1990. In its respondent's brief, SAIF contends that the Referee erred in modifying claimant's medically stationary date from September 12, 1989, as found by a Determination Order, to February 28, 1990. On review, the issues are medically stationary date, temporary disability and offset. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSION OF LAW AND OPINION

On November 9, 1989, an earlier Referee directed SAIF to accept claimant's March 1989 aggravation claim. (Ex. 11A). The question before us now is the date by which claimant subsequently became medically stationary as a result of that aggravation.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. Schuening v. J.R. Simplot & Co., 84 Or App 622, 625 (1987). Claimant bears the burden of proving that she was medically stationary at the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

In this case, there is no explicit statement that claimant was medically stationary on September 12, 1989. Nonetheless, "magic words" are not necessary to establish a medically stationary date and circumstantial medical evidence is as effective as a direct statement. Henry Martin, 43 Van Natta 2561, 2562 (1991); also see Austin v. SAIF, 48 Or App 7 (1980); Paul E. Voeller, 42 Van Natta 1775 (1990). After our review of the record, we disagree with the Referee's finding that claimant's condition was not medically stationary until February 28, 1990.

Dr. Munley, M.D., claimant's first treating physician, reported that when he saw claimant on March 30, 1989, his findings were not significantly different from those on previous examinations. (Ex. C). Dr. Munley further noted that the March 1989 examination was not unlike those in the past when claimant was experiencing a temporary exacerbation. Dr. Munley reported that claimant's condition seemed to be somewhat static. (Ex. C).

Dr. Bennett, rheumatologist, saw claimant on referral from Dr. Munley. Bennett prescribed physical therapy treatments three times a week from May 1989 through July 1989. (Tr. 14; Ex. 6). Claimant also received injections from Dr. Bennett on May 11, June 20, and September 26, 1989. (Ex. 2). During this period, a May 23, 1989 MRI revealed normal findings for claimant's left shoulder. (Ex. 8).

Since claimant began physical therapy on May 19, 1989, her condition essentially did not vary. (Ex. 6). Claimant continued to complain of pain with good days and bad days. (Ex. 6). Consequently, on July 26, 1989, Dr. Zivin, neurologist, on referral by Dr. Bennett, reported that physical therapy was no longer necessary. (Ex. 6-4).

Thereafter, the physical therapist advised Dr. Bennett that claimant's progress was slow, but that physical therapy was helping her to manage her pain level. Dr. Bennett, who had only treated claimant twice during this time, recommended that the physical therapist teach claimant and her spouse how to perform the physical therapy at home. (Ex. 6-4). After two instructions, claimant began receiving physical therapy in August 1989 from her husband on an as needed basis. (Ex. 6-4; Tr. 24).

On September 12, 1989, claimant was examined by Dr. Zivin for a third time. (Ex. 11). Dr. Zivin reported:

> "I do not feel that there are any requirements for therapy. Certainly [claimant] is capable of any of a variety of jobs for which she is capable by virtue of experience and training. There are minimal restrictions relative to lifting and/or prolonged overhead use of the arms." (Ex. 11-4).

Dr. Zivin further advised claimant to avoid injections and deep vigorous massage to the area in question because he suspected she was actually incurring repetitive injuries to the area through therapeutic intervention. (Ex. 11-4).

Based on Dr. Zivin's comment, claimant contends Dr. Zivin's opinion is inconsistent with the notion that she was medically stationary. (App. Br. at 11). We disagree. We interpret Dr. Zivin as providing his reasons for recommending that claimant discontinue physical therapy. In light of Dr. Zivin's recommendation and subsequent cessation of administering injections, we find the most logical interpretation of his statement of "incurring repetitive injuries" to indicate his explanation for why claimant was not improving with physical therapy. Inasmuch as Zivin did not recommend further therapy, we consider his opinion to be supportive of the proposition that no material improvement in claimant's condition was reasonably to be expected from medical treatment or the passage of time. See ORS 656.005(17).

Accordingly, we conclude that claimant's condition was medically stationary by September 12, 1989. For this conclusion, we rely on: (1) Dr. Bennett's July 1989 recommendation of home physical therapy; (2) Bennett's assessment that claimant seek further care on an as needed basis; and (3) the fact that Dr. Bennett did not find it necessary to schedule future appointments or provide medical treatment for claimant beyond the three injections given in May, June and September 1989. See Willa D. Tucker, 42 Van Natta 1281, 1283 (1990). We further note that claimant did not receive another injection from Dr. Bennett until February 1990, five months later, and, during that time, she did not receive any treatment.

Claimant's testimony does not alter our conclusion concerning her medically stationary date. Claimant testified that in the latter part of 1989 she was pretty much on an "even keel" and only sought treatment from Dr. Bennett on an as needed basis. (Tr. 18, 19). Although claimant testified that she believed she had improved after February 1990 and became medically stationary in May 1990 (Tr. 25-27), there is no medical evidence in the record to support this alternative suggestion.

Accordingly, we conclude that claimant became medically stationary on September 12, 1989. In light of this conclusion, we need not address the question of whether the Referee improperly raised the "withdrawal from the work force" issue.

Offset

Because we have concluded that claimant was medically stationary on September 12, 1989, claimant is not entitled to temporary disability after that date. Soledad Flores, 43 Van Natta 2504 (1991). Consequently, SAIF is entitled to offset temporary disability paid between September 12, 1989 and February 15, 1990 against claimant's current and future permanent disability awards.

Extent of Permanent Partial Disability

We adopt the Referee's Opinion and Conclusion on this issue.

ORDER

The Referee's order dated February 8, 1991 is reversed in part and affirmed in part. The February 15, 1990 Determination Order is reinstated and affirmed insofar as it found claimant's condition medically stationary as of September 12, 1989 and awarded temporary disability through that date. The SAIF Corporation is authorized to offset temporary disability paid between September 12, 1989 and February 15, 1990 against claimant's current and future permanent disability awards. The remainder of the order is affirmed.

In the Matter of the Compensation of
EDWIN W. PEARLE II, Claimant
WCB Case No. 90-17837
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Kinsley, Tenenbaum and Gunn.

The insurer requests review of Referee Black's order which set aside the insurer's denial insofar as it denied claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDING OF FACTS

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

We do not find that claimant's symptoms, as developed on or about July 7, 1990, are materially related to his October 11, 1988 injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's 1990 low back condition to be a compensable aggravation of his original work-related low back strain. We disagree.

The dispositive issue is whether claimant has sustained his burden of proving that his condition was materially related to his compensable injury. See Grable v. Weyerhaeuser, 291 Or 387, 401 (1981). To sustain his burden of proof, claimant offers his own statement and the reports of Drs. Mentzer and Kitchel.

Claimant's treating physician, Dr. Mentzer, M.D., diagnosed "recurrent low back strain with left sciatica and left sacroiliitis." (Ex. 10A-1). Dr. Mentzer made no findings as to causation. His opinion is, therefore, not persuasive on the issue of causation.

Dr. Kitchel, an orthopedic surgeon, reported: ". . . I do believe that November 10, 1988 work injury is the major contributing cause of his ongoing problem and current need for treatment. I make this judgement based upon the history which [claimant] provides as well as the medical records which have been forwarded to me from Dr. Mentzer." (Ex. 20).

Although there is no contradictory medical evidence in the record, we conclude that claimant has not sustained his burden of establishing a causal nexus between his employment and his disability.

Considering the complexity of the causation issue concerning claimant's medical condition, we accord claimant's lay conclusions little weight. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Moe v. Ceilings Systems, 44 Or App 429, 433 (1980). Further, claimant's conclusion is inconsistent with the evidence that he functioned quite well and had no treatment between November 1988 and July 1990. Dr. Kitchel's bare conclusion is likewise not persuasive, as he merely relies upon claimant's statements and Dr. Mentzer's medical reports, which contain no analysis of the cause of claimant's condition. Moreover, Dr. Kitchel does not explain his finding, nor is it documented by Dr. Mentzer's notes. Accordingly, claimant has failed to carry his burden of proof. Moe, supra.

ORDER

The Referee's order dated February 20, 1991 is reversed. The insurer's denial is reinstated and upheld. The award of an attorney fee to claimant's attorney is also reversed.

Board member Gunn dissenting.

The majority's conclusion can only be reached by the metamorphosis of the evidence. The Board ignores claimant's testimony as to causation. Although the Referee made no specific findings on credibility, he did find claimant's denials that off-work activities contributed to a worsening sufficient evidence to dismiss the employer's contentions as follows: "There is nothing in the record that would justify further cavilling with respect to this denial." The Referee clearly relied on claimant's testimony as to that issue as dispositive of the matter. I would hold this implies a finding that claimant was credible.

The majority could be correct in dismissing claimant's testimony as merely "a layperson's analysis,"[1] however, his testimony is supported by the opinions of the treating physician and Dr. Kitchel. There is no contradictory evidence on causation. Even the employer does not advance the argument that the medical evidence does not sustain causation.[2]

The majority goes on to dismiss Dr. Kitchel's report as "bare conclusion." Yet the good doctor actually saw claimant, examined him and reviewed the treating physician's records before reaching this "bare conclusion." I submit that when required to choose between the medical opinion of two lawyers and a doctor who saw the patient and reviewed the medical records, I will defer to the doctor.

Lastly, under Senate Bill 1197 many limitations were placed on workers' ability to obtain compensation for injuries or aggravations. To ignore medical evidence, actual "magic words," the absence of contrary evidence or argument, and overturn the well-reasoned opinion of the Referee, leaves me wondering if any injury/aggravation can be found compensable.

I dissent.

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1 My respected colleagues are well-educated and greatly experienced in workers' compensation, law but I would submit they are also applying a "layperson's analysis" to a question of medicine.

2 The employer argues that Dr. Kitchel did not have knowledge of outside activities that may have been agents of causation.

January 10, 1992 Cite as 44 Van Natta 43 (1992)

In the Matter of the Compensation
GARY L. WALDRUPE, Claimant
WCB Case Nos. 90-17608 & 90-13576
SECOND ORDER OF ABATEMENT
Welch, et al., Claimant Attorneys
Roderick D. Peters (Saif), Defense Attorney
VavRosky, et al., Defense Attorneys

On January 7, 1992, we issued an Order of Abatement granting the self-insured employer an opportunity to respond to claimant's motion for reconsidera

tion of the Board's December 13, 1991 Order on Review. Although captioned as an abatement order, the order did not expressly state that the December 13, 1991 Order on Review had been withdrawn.

In the interests of clarification, the Board's January 7, 1992 Order of Abatement is supplemented to provide that the December 13, 1991 Order on Review is withdrawn for reconsideration. The employer's response to claimant's motion shall continue to be due within 14 days of the Board's January 7, 1992 Order of Abatement.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAUL F. WEIGEL, Claimant
WCB Case No. 90-15250
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of Referee Black's order that: (1) affirmed the Determination Order award of 7 percent (13.44 degrees) scheduled permanent disability for the loss of use or function of the right arm; (2) increased his unscheduled permanent disability award for a chest injury from 14 percent (44.8 degrees), as awarded by Determination Order, to 29 percent (92.8 degrees); and (3) declined to assess a penalty and related attorney fee for the SAIF Corporation's allegedly unreasonable claims processing. On review, the issues are extent of permanent disability, scheduled and unscheduled, and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

Claimant seeks increased awards of permanent partial disability compensation, scheduled and unscheduled. We modify both awards.

The Referee applied to this case the standards for evaluating permanent disability that were in effect at the time of the February 21, 1990 Determination Order. See former ORS 656.283(7); WCD Admin. Order 7-1988. We apply the same standards.

Scheduled Disability

The parties do not dispute the Referee's conclusion that claimant's lost ranges of motion in the right wrist add to a total of 7 percent scheduled permanent disability under the standards. We therefore adopt that conclusion.

Claimant seeks an award of 40 percent scheduled permanent disability based on the Orthopaedic Consultants' August 8, 1989 report. (Ex. 26). In that

report, Drs. Marble and Brown diagnosed non-union right scaphoid fracture with early post-traumatic degenerative changes, and opined:

> "[W]e will on the basis of our personal observations of the effects of injuries of this type on numerous patients, suggest that [claimant's] wrist should be rated as exhibiting a 40 percent loss of function which in the absence of any surgical procedure should be anticipated to be permanent."

However, Drs. Marble and Brown do not specify findings to which we can apply the standards for calculating permanent disability. Absent those findings, we are unable to award additional scheduled disability under the standards.

Claimant also seeks an additional award for loss of grip strength and wrist strength. Former OAR 436-35-110(3) provides for the rating of decreased grip strength. We agree with the Referee, however, that claimant's loss of grip strength cannot be quantified based on the medical reports in this record. The Orthopaedic Consultants rated claimant's grip strength as "90 KPA" (Ex 26-4), but did not indicate what percentage of grip strength was lost due to the compensable injury. Dr. Smith, the attending physician, reported "considerable weakness of grip on the right side, measuring 45-40-40 on the Jamar dynamometer" (Ex 23-1), but did not quantify what percentage of grip strength was lost.

Besides the lack of a quantifiable loss of grip strength, we cannot find a useful standard for rating loss of grip strength in the AMA Guidelines for Rating Permanent Disability. See OAR 436-35-005(1). Accordingly, we are unable to rate claimant's loss of grip strength. See Jay D. Marrington, 42 Van Natta 2871 (1990).

Finally, claimant contends that his permanent disability due to loss of grip and wrist strength exceeds the value provided by application of 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), 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).

The Referee declined to award permanent disability outside the standards, citing ORS 656.325(4) as a "compelling reason." The Referee's refusal was evidently based on a finding that claimant unreasonably refused to undergo bone graft surgery on the wrist, which was recommended by Dr. Smith. We disagree.

ORS 656.325(4) authorizes the Director, not a Referee, to reduce any benefits awarded to a worker, based on the worker's failure to follow medical advice from the attending physician. Therefore, that statute does not apply here. Parenthetically, we would not conclude on this record, that claimant had failed to follow his physician's advice or refused to participate in physical restoration.

However, there is case law permitting a reduction of permanent disability benefits if the worker unreasonably refuses to submit to recommended treatment. Clemons v. Roseburg Lumber Co., 34 Or App 135 (1990). Here, we do not find that claimant's refusal to undergo surgery was unreasonable. Although Dr. Smith estimated an 80 percent chance of success with surgery (Tr. 56), he only described as "possib[le]" the likelihood that surgery would increase strength. (Ex. 23-2). Additionally, claimant was told the procedure would be painful due to the necessity of removing bone from the donor site. (Tr. 56). Finally,

Smith had previously estimated an 80 percent chance of success with bone stimulator therapy, which claimant elected in lieu of surgery, but it had failed. (Tr. 35, 56). Under these circumstances, it was reasonable for claimant to forgo the pain of wrist surgery. See Clemons, supra, 34 Or App at 140; Maryanne Champagne, 42 Van Natta 224 (1990).

We therefore proceed to consider whether claimant's permanent loss of use or function of the wrist exceeds his entitlement under the standards. Although there are insufficient findings to award claimant additional scheduled disability under the standards, the medical experts are in agreement that claimant suffers significant disability due to the non-union fracture.

Dr. Smith reported that claimant has wrist pain and weakness, particularly with dorsiflexion (backward bending), and "considerable" weakness of grip strength. (Ex 23). Smith also reported that claimant is unable to do significant work with the wrist and is not capable of operating a chainsaw. (Ex 23). Claimant testified that he has had to "cut back" on several activities involving use of the wrist, including rowing, kayaking, and gripping a hammer. (Tr. 33). Finally, as we discussed above, the Orthopaedic Consultants opined, based on their personal observations of numerous patients with the same condition, that claimant has 40 percent permanent loss of wrist function due to the non-union. (Ex. 26-6).

Based on the aforementioned evidence, which we find persuasive, particularly the Orthopaedic Consultants' report, we conclude that claimant has established by clear and convincing evidence that he has sustained a 40 percent permanent loss of use or function of the right forearm (wrist). Converting that loss to a loss in the right arm, we find that claimant has a 32 percent impairment of the arm. See former OAR 436-35-090. Subtracting the 7 percent impairment calculated under the standards, we conclude that claimant has sustained 25 percent impairment in excess of his entitlement under the standards. We therefore award, outside of the standards, an additional 25 percent scheduled permanent disability for the loss of use or function of the right arm.

Unscheduled Disability

We adopt the Referee's conclusions and opinion concerning this issue, except the final two paragraphs, with the following supplementation.

The determination of unscheduled permanent 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.

Claimant challenges the +2 value that the Referee assigned to the adaptability factor. The Referee assigned that value based on his finding that claimant had been performing work requiring medium physical capacity at the time of injury. We disagree.

Claimant testified that his logging job required carrying jacks weighing 60 pounds, a chain saw weighing 25 pounds, and gas and oil weighing another 16 pounds. (Tr. 21). Based on his testimony, we find that claimant's usual and customary work required heavy physical capacity. It is undisputed that claimant's modified job requires light physical capacity. Therefore, using the matrix in former OAR 436-35-310(3), we assign the adaptability factor a value of +2.5.

We now proceed to the calculation of unscheduled disability. 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 2.5, the product is 7.5. When that value is added to claimant's impairment value 23, the result is 30.5 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, 31 percent.

Finally, claimant contends that his unscheduled permanent disability exceeds his entitlement under the standards. He maintains that he is capable of sedentary work only, due to his rib fractures and pulmonary condition. We find insufficient evidence to prove that claimant is permanently limited to sedentary work. Furthermore, we are persuaded that the permanent limitations due to his chest condition were adequately considered in determining the impairment value under the standards. Accordingly, we do not find clear and convincing evidence that claimant's unscheduled disability exceeded his entitlement under the standards. Former ORS 656.283(7); 656.295(5).

Penalties

We adopt the Referee's reasoning and conclusions regarding this issue.

ORDER

The Referee's order dated January 11, 1991, is modified in part and affirmed in part. In addition to the 7 percent (13.44 degrees) scheduled permanent disability awarded by the Determination Order, claimant is awarded 25 percent (48 degrees) scheduled disability, giving him a total scheduled permanent disability award of 32 percent (61.44 degrees) for the loss of use or function of the right arm. In addition to the 29 percent (92.8 degrees) unscheduled permanent disability awarded by the Determination Order and the Referee, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, giving him a total unscheduled permanent disability award of 31 percent (99.2 degrees) for a chest injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and the Board shall not exceed $3,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
BETTY R. YOUNG, Claimant
WCB Case No. 91-0111S
ORDER ON REVIEW
Green, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Daughtry's order that declined to approve the parties' stipulation concerning the extent of claimant's unscheduled permanent disability. Relying on OAR 438-09-005(1), the Referee reasoned that the Hearings Division was without authority to approve the stipulation because claimant's condition became medically stationary after July 1, 1990 and no Order on Reconsideration under ORS 656.268(5) and (6) had issued. The insurer also seeks remand for an evidentiary hearing. Alternatively, contending that the

rule exceeds the Board's statutory authority, the parties seek approval of the resubmitted stipulation. We deny the motion to remand and affirm.

FINDINGS OF FACT

On August 28, 1990, a Determination Order issued closing claimant's injury claim. Claimant was awarded 11 percent unscheduled permanent disability. The Determination Order also found claimant to be medically stationary as of July 18, 1990.

In February 1991 the parties submitted to the Hearings Division a proposed stipulation purporting to resolve the extent of permanent disability issue. Pursuant to the stipulation, claimant's unscheduled permanent disability award was increased from 11 percent to 26 percent. When the Referee declined to approve the stipulation, the insurer sought Board review.

CONCLUSIONS OF LAW

When a claim is closed by Determination Order, an objecting party must first request reconsideration of the Determination Order. Amended ORS 656.268(5). Thereafter, if a party disagrees with the reconsideration, the party may request a hearing within 180 days after mailing of the Determination Order. Amended ORS 656.268(6)(b). These statutory amendments apply to all claims existing on and after July 1, 1990 where the claimant's condition became medically stationary after July 1, 1990. 1990 Oregon Laws (Special Session), chapter 2, section 54(3).

Here, the August 28, 1990 Determination Order found claimant's condition to be medically stationary on July 28, 1990. In reaching this finding, we note that a copy of the Determination Order has not been submitted into the record as evidence. Nevertheless, since the Determination Order is capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned, we take administrative notice of its existence and findings. Grace B. Simpson, 43 Van Natta 1276, 1277 (1991).

Since claimant's condition became medically stationary after July 1, 1990, and application of the 1990 amendments will not produce an absurd or unjust result, the amendments to ORS 656.268 are applicable. 1990 Oregon Laws (Special Session), chapter 2, section 54(3); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991). Thus, before a party objecting to the Determination Order may seek a hearing, that party must first request reconsideration under ORS 656.268(5). Such a conclusion is further confirmed by amended ORS 656.319(4), which now provides that a party may seek a hearing concerning a "reconsideration order," whereas the statute previously provided for a hearing regarding a "determination or notice of closure." See Lorna D. Hilderbrand, supra.

In accordance with the statutory scheme, the Board's authority to approve proposed stipulations concerning issues arising out of claim closure is contingent upon conclusion of the reconsideration procedure under ORS 656.268. OAR 438-09-005(1). Specifically, the Board rule provides as follows:

> "Contested matters arising out of a claim closure may be resolved by the parties at any time after the conclusion of the reconsideration proceeding by Evaluation under ORS 656.268, whether or not a hearing has been requested by a party." (Emphasis supplied).

The parties contend that OAR 438-09-005(1) exceeds the Board's statutory authority in that it restricts the parties' ability to resolve disputes

regarding permanent disability until after the reconsideration proceeding. We disagree.

As previously discussed, OAR 438-09-005(1) is consistent with the current statutory scheme, which requires a party contesting a Determination Order to first seek reconsideration by the Evaluation Section pursuant to ORS 656.268(5). Were we to accede to the parties' wishes and approve a stipulation concerning a dispute that is subject to the reconsideration proceeding, we would be taking an action in direct contravention of the statutory scheme.

OAR 438-09-005(1) does not prevent the parties from resolving such disputes. We are unaware of any statute or administrative rule prohibiting the Evaluation Section from considering stipulations resolving disputes subject to the reconsideration proceeding. In fact, we note that the Director has proposed a rule which would permit the Hearings Division to consider stipulations that are submitted while a request for reconsideration is pending. See proposed OAR 436-30-050(24). In any event, should the Evaluation Section decline to approve such stipulations, we are likewise unaware of a statutory or administrative restriction preventing a Referee from considering a proposed stipulation submitted after completion of the reconsideration proceeding.

In conclusion, we hold that because neither party sought reconsideration of the Determination Order prior to submitting the stipulation for Referee approval, the Referee lacked authority to consider the agreement. Accordingly, we affirm the Referee's holding that the Hearings Division was without jurisdiction to approve the stipulation.

Finally, the insurer requests that this matter be remanded to the Referee for an evidentiary hearing. We may remand if we find the record inadequately, incompletely, or otherwise insufficiently developed. ORS 656.295(5). To remand, it must be clearly shown that material evidence was not obtainable at the time of hearing with the exercise of due diligence. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

Here, other than seeking an "evidentiary hearing," the insurer does not identify what evidence it proposes to submit into the record on remand. Such circumstances do not lead us to conclude that this "evidence" was previously unobtainable with the exercise of due diligence. Moreover, neither party has registered an objection to the July 18, 1990 medically stationary finding by the Evaluation Section. Since that finding is crucial to a determination of the Hearings Division's authority to consider the stipulation, we consider the record sufficiently developed to consider our review. Consequently, the motion to remand is denied.

ORDER

The Referee's order dated March 7, 1991 is affirmed.

In the Matter of the Compensation of
LUIGI CARTASEGNA, Claimant
WCB Case Nos. 90-11865 & 90-10091
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Williams, et al., Defense Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld Liberty Northwest Insurance Company's denial of his aggravation claim for his current low back condition; (2) upheld Sedgwick James & Company's denial of his occupational disease claim for his low back condition; and (3) upheld Liberty Northwest's denial of his chiropractic treatments in excess of the guidelines. On review, the issues are aggravation, compensability and medical services. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact. In addition, we note that, although under her "Issues" section the Referee referred to Sedgwick James' denial of May 10, 1990, the denial of chiropractic treatment issued on May 10, 1990 was actually issued by Liberty Northwest.

CONCLUSIONS OF LAW AND OPINION

Aggravation and Compensability

We adopt those portions of the Referee's order discussing claimant's aggravation and new occupational disease claims.

Medical Services

The Referee concluded that claimant had not established that chiropractic treatment in excess of the guidelines was either reasonable or necessary. Consequently, she upheld Liberty Northwest's denial of such treatment. We conclude that the Referee lacked jurisdiction to address the medical services issue.

Subsequent to the Referee's order, we determined that amended ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." Stanley Meyers, 43 Van Natta 2643 (1991). We concluded that, in cases such as the present one which involve a denial on the ground that the treatment is excessive, original jurisdiction lies exclusively with the Director. Meyers, supra.

Accordingly, we vacate that portion of the Referee's decision insofar as it purports to uphold the denial, as the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division.

ORDER

The Referee's order dated March 1, 1991 is affirmed in part and vacated in part. That portion of the Referee's order that upheld Liberty Northwest's denial of medical services is vacated. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DEBBIE K. ZIEBERT, Claimant
WCB Case No. C1-02683
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Gatti, Gatti, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

On December 11, 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 for the following reasons.

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) (Emphasis added). See also OAR 438-09-001(1).

Although the proposed disposition provides that claimant retains her right to medical services for the compensable injury, the agreement also states that it "will serve to close this claim and claimant will be medically stationary on the date that this document is signed by the Board." The function of a claim disposition agreement is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board receives the CDA. See ORS 656.236(1). It is not the function of a CDA to accomplish claim processing functions under ORS 656.262. There are other procedural avenues available to the parties to accomplish these objectives, such as stipulations and disputed claim settlements. See Frederick M. Peterson, 43 Van Natta 1067 (1991). Here, however, the agreement attempts to serve as a device for claim closure.

Moreover, it states that claimant will be found medically stationary on the date that the disposition agreement is signed by the Board. Pursuant to amended ORS 656.245(1)(b), a claimant's entitlement to medical services is substantially limited on reaching medically stationary status. Here, however, claimant may or may not be medically stationary. Because claimant's medically stationary status is not susceptible to ready determination, we are unwilling to approve an agreement which could be reasonably interpreted as a partial release of claimant's statutory right to medical services. Keely K. Wilson, 43 Van Natta 1365 (1991).

Inasmuch as the agreement attempts to accomplish processing functions and could reasonably be interpreted as involving a release of medical services, the claim disposition agreement impermissibly exceeds the bounds of OAR 438-09-020(1)(b). Therefore, we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). See Frederick M. Peterson, supra.

We further conclude that the proposed agreement is unreasonable as a matter of law on an additional basis. We note in this regard that the agreement provides that, out of the total agreement proceeds, claimant's counsel is to receive both a $1,000 attorney fee and costs in the amount of $50. We have no way of verifying the accuracy of such costs. Further, although the attorney fee payable to claimant's counsel is to be prescribed by the Board pursuant to ORS

656.236(4) and OAR 438-15-052, costs incurred by an attorney in pursuing a matter on behalf of a party are not included in fees paid to an attorney. OAR 438-15-005(6). See Janelle I. Neal, 40 Van Natta 359 (1988). Moreover, ORS 656.234 prohibits the assignment by an injured worker or any other beneficiary of any "moneys payable under ORS 656.001 to 656.807" prior to their receipt. Because the agreement proceeds here are payable under ORS 656.236, such proceeds cannot be assigned by claimant prior to their receipt. For these reasons, we conclude that the portion of the CDA providing for payment of costs to claimant's counsel is unreasonable as a matter of law.

Because the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we conclude that we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CORDY A. BRICKEY, Claimant
Own Motion No. 66-0302M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for medical benefits allegedly related to his 1953 low back injury. SAIF recommends denial of the claim on the ground that claimant's current condition requiring surgery is not compensably related to claimant's 1953 injury. SAIF also requests reimbursement for a narrative report it sought regarding the compensability of claimant's claim.

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, the medical evidence indicates that claimant's original injury resulted in a herniated disc at L5-S1 on the right side. Dr. Weinman opined that claimant's current L2-3 and L3-4 decompression surgery on the left is unrelated to his 1953 injury, as it was at a different level and on the opposite side. No contrary evidence has been submitted. Accordingly, we find that claimant's current condition is unrelated to his compensable 1953 injury. We consequently deny payment for claimant's July 10, 1991 left L2-3 and L3-4 decompression surgery and related medical benefits. Id.

We next turn to SAIF's request for reimbursement of the narrative report it solicited to evaluate the relationship between claimant's current condition and his 1953 injury. ORS 656.625 allows for reimbursement from the Reopened Claims Reserve only for "compensation payable to injured workers." "Compensation" includes all benefits, including medical services, provided for a

compensable injury to a subject worker. ORS 656.005(8). A medical report to determine compensability is not compensation as defined by ORS 656.005(8). We accordingly deny SAIF's request for reimbursement for the report.

Inasmuch as our reasoning regarding the reimbursement for a narrative report to establish compensability differed in Henry J. Dolinar, issued January 17, 1991 (unpublished), we disavow that portion of that order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA L. NELSEN, Claimant
WCB Case No. 89-26009
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Miller, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Lipton's order that upheld the insurer's December 7, 1989 partial denial of her claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. The hearing was convened after July 1, 1990. Therefore, the litigation savings clause contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See, e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Law as amended effective July 1, 1990.

Claimant's claim for a psychological condition is based on her contention that her psychological problems are a compensable consequence of her 1982 compensable right foot injury.

Claimant bears the burden of proving that her compensable injury is the major contributing cause of her allegedly consequential psychological condition. ORS 656.005(7)(a)(A); Julie K. Gasperino 43 Van Natta 1151 (1991). Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991).

Claimant correctly observes that "magic words" are not necessary to carry her burden. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). However, due to the passage of time since the 1982 injury and the number of

potentially causal factors in this case, the causation issue is a complex medical question. Therefore, 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. Blood, M.D., and Leslie Bennett, M.S., offer the only expert opinions concerning the causation of claimant's current need for psychological treatment. Ms. Bennett opined that claimant's work injury is a material contributing cause of her need for counseling. (Ex. 59). Dr. Blood stated:

> "I do think [claimant] does require some psychotherapy to get her Workmen's Compensation case terminated. Such psychotherapy would be addressed to her pain problem, and obviously her attention-seeking complex is a part of the difficulty mixed in with the pain situation, and therefore it would be involved in the treatment as well as the pain." (Ex. 63-8).

Inasmuch as Dr. Blood was apparently unaware of claimant's intervening back injury and its sequelae, particularly pain, he did not have an accurate history of potentially causal factors underlying the current claim. Therefore, his opinion is not persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Moreover, even if Dr. Blood did have an accurate history, he did not quantify the relative contributions of the various causal factors which he identified. We conclude that neither Dr. Blood's nor Ms. Bennett's reports support a finding that the 1982 injury is the major cause of claimant's psychological problems. See David K. Boyer, supra. Consequently, claimant has not carried her burden.

ORDER

The Referee's order dated March 4, 1991 is affirmed.

January 14, 1992 Cite as 44 Van Natta 54 (1992)

In the Matter of the Compensation of
LARRY S. OLSON, Claimant
WCB Case No. 90-22247
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

The insurer requests review of Referee Leahy's order that: (1) increased claimant's scheduled permanent disability for the loss of use or function of the left arm from 16 percent (30.72 degrees), as awarded by Determination Order, to 41 percent (78.72 degrees); and (2) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issues are the extent of scheduled permanent disability and the rate of scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following modifications.

We do not find that claimant's partial losses of left forearm (wrist) dorsiflexion, palmar flexion, and grip strength are due to the June 1989 injury. We find that claimant has normal range of extension in the left elbow. We do

not find that the chronic limitation on claimant's ability to lift over 10 pounds is due to the June 1989 injury.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Disability

Claimant bears the burden of proving by a preponderance of the evidence that he is entitled to permanent disability benefits. ORS 656.266; Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). The Referee applied to this case the standards for evaluating permanent disability that were in effect at the time of the July 18, 1990 Determination Order. See former ORS 656.283(7); WCD Admin. Order 7-1988. We apply the same standards.

The insurer argues that the Referee erred in finding that claimant sustained the following permanent impairments due to the June 1989 injury: (1) losses of left forearm (wrist) dorsiflexion and palmar flexion; (2) loss of left elbow extension; (3) loss of left hand grip strength; and (4) loss of ability to repetitively move left forearm or lift 10 pounds with it. We address each contention below.

The Referee assigned values of 3 and 4 percent for partial losses of dorsiflexion and palmar flexion in the left wrist. He apparently relied on the Northwest Pain Center's May 22, 1990 report, which reported that claimant retained 45 degrees in dorsiflexion and 45 degrees in palmar flexion. (Ex. 25). The insurer agrees with the range of motion findings, but argues there is no evidence relating those losses to the June 1989 injury. We agree.

Claimant has preexisting rheumatoid arthritis that has deformed both hands and interferes with the use of the left arm. (Ex. 14-1, 20). Because claimant's impairment may relate, in part, to the noncompensable arthritis condition, the causation issue is a complex medical question. The resolution of this issue largely turns on the medical evidence. See 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).

There is no medical evidence that specifically relates the loss of left wrist dorsiflexion and palmar flexion to the June 1989 injury. Indeed, claimant had the same ranges of motion in his right wrist which was not part of the compensable claim. (Ex. 25-4). That suggests the losses of dorsiflexion and palmar flexion are unrelated to the June 1989 injury. Further, his complaint of pain to the Northwest Pain Center was on supination, not dorsiflexion or palmar flexion. Accordingly, we decline to assign any values based on those findings.

The Referee also assigned a value of 3 percent based on a finding that claimant partially lost left elbow extension due to the injury. The Referee relied on Dr. Fagan's December 29, 1989 chart note, which reported that claimant lost 15 degrees in extension. (Ex. 19). However, Dr. Fagan's report is dated almost five months before claimant had attained medically stationary status, and it reports that claimant's elbow had worsened at that time. After that report, claimant's elbow improved (Ex. 22, 23, 24) and he became medically stationary on May 22, 1990. On that date, claimant had full extension in the elbow. (Ex. 25-4). Accordingly, claimant is not entitled to any value for a loss of left elbow extension.

The Referee assigned a value of 25 percent for loss of grip strength in the left hand. He evidently relied on the Northwest Pain Center's report that the left grip strength was 35 pounds, whereas the right grip strength was 65 pounds. (Ex. 25-5). However, there is medical evidence that claimant's loss of

grip strength is due to the rheumatoid arthritis condition. (Ex. 14-2). There is no persuasive evidence that adequately separates out and relates the loss of left grip strength to the June 1989 injury. Accordingly, claimant is not entitled to any value for loss of grip strength.

Finally, the Referee assigned a value of 5 percent based on findings that claimant cannot repetitively move his left forearm or lift more than 10 pounds. The Referee based his findings on the Northwest Pain Center's report. (Ex. 26-2). The insurer contends that claimant's chronic condition limiting repetitive use is not related to the June 1989 injury. We disagree.

Dr. Fancher, examining physician, was the only medical expert to address the relationship between the chronic condition and the June 1989 injury. He wrote:

> "[Claimant] has chronic soreness of his neck and left shoulder related to his previous work injuries [in 1979 and 1985]. He has limited ability to lift anything more than five pounds with his left arm. He has recently had chronic aching around his left elbow and left forearm related to his work injury in June [1989]." (Ex. 13-3)

Based on Dr. Fancher's opinion, we find that the chronic limitation on lifting is due to prior work injuries, not the June 1989 injury. However, we also find that the chronic aching, which limits repetitive use of the left forearm, is due to the June 1989 injury. (Ex. 26-2). Accordingly, claimant is entitled to 5 percent for that condition. See former OAR 436-35-010(7).

The sum of the losses of left forearm motion is 6 percent based on 5 degrees retained radial deviation (3) and 15 degrees retained ulnar deviation (3). See former OAR 436-35-080(5), 436-35-080(7) and 436-35-080(9). When combined with the 5 percent finding for a chronic condition, the total is 11 percent. See former OAR 436-35-080(11). Converting that forearm loss to a loss in the arm, the value is 8 percent. See former OAR 436-35-090.

The sum of the losses of left arm motion is 12 percent based on 35 degree loss of pronation (6) and supination (6). See former OAR 436-35-100(4) and 436-35-100(6). When that loss is combined with the 8 percent loss, the total is 19 percent. Accordingly, we modify the Referee's scheduled permanent disability award to 19 percent.

Rate of Scheduled Disability

The Referee concluded that claimant's scheduled permanent disability award should be paid at the rate of $305 per degree. We agree.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the amendment to ORS 656.214(2) in Oregon Laws 1990, chapter 2, section 7, which increased the value per degree of scheduled permanent disability to $305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because claimant's award of scheduled permanent disability was made after May 7, 1990, the Referee correctly concluded that the award should be paid at the rate of $305 per degree.

ORDER

The Referee's order dated May 8, 1991 is modified in part and affirmed in part. In lieu of the Referee's award of 25 percent (48 degrees) scheduled

permanent disability, and in addition to the Determination Order award of 16 percent (30.72 degrees) scheduled permanent disability, claimant is awarded 3 percent (5.76 degrees) scheduled permanent disability, giving him a total scheduled award of 19 percent (36.48 degrees) for the loss of use or function of the left arm. The remainder of the Referee's order is affirmed.

January 14, 1992 Cite as 44 Van Natta 57 (1992)

In the Matter of the Compensation of
THOMAS R. PRINCE, Claimant
WCB Case No. C1-02687
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Baum & Riedlinger, Claimant Attorneys

Reviewed by Board Members Neidig and Moller.

On December 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 a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

The submitted disposition agreement has been processed as required in all aspects except one. Whereas the disposition agreement has been provided, the parties have not filed six copies of the agreement along with the original pursuant to OAR 438-09-025(1).

Under these circumstances, we find the omission of six legible copies of the claim disposition agreement constitutes an inadvertent error. Therefore, we approve the proposed agreement.

This agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of this agreement is also approved.

IT IS SO ORDERED.

January 14, 1992 Cite as 44 Van Natta 57 (1992)

In the Matter of the Compensation of
GERALD D. SPENCER, Claimant
Own Motion No. 66-0226M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
SAIF Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for medical benefits and temporary total disability compensation for a worsened condition and hospitalization allegedly resulting from claimant's September 10, 1963 right leg fracture and a large avulsion flap of the popliteal space and calf. Claimant has had skin grafts to this area; the scar area lacks feeling. SAIF opposed the reopening of claimant's claim on the ground that claimant's right leg condition that required hospitalization on December 5, 1990 could have been the result of a 1988 or 1990 claim when a different insurer was on the risk, or due to off-

the-job causes such as a burn incident, diabetes and obesity. By a September 12, 1991 Own Motion Order, we authorized an independent medical report and a written response from claimant's attending physician regarding the causal relationship of the hospitalization to the 1963 injury, pursuant to OAR 438-12-037(1)(f). In that order we required "opinions as to the relative contributions of each of the aforementioned incidents or medical conditions to claimant's need for hospitalization in December 1990."

Drs. Buie and Stanton, who performed an independent medical examination on October 4, 1991, diagnosed claimant's current condition, which was a new complaint of an "ulcer behind my knee, one month," as "recurrent ulceration in the popliteal area [posterior surface of the knee] secondary to scar contracture and other associated factors including obesity, smoking, diabetes, and previous cellulitis." Neither doctor addressed the compensability of the condition for which claimant was hospitalized in December 1990, and for which he requested claim reopening. Because the independent medical report is unresponsive to the questions formulated in our September 10, 1991 order, and because we have not received a report from Dr. Conner, claimant's treating physician, regarding the causal relationship of the hospitalization to the 1963 injury, we turn to the notes made by Dr. Conner at the time claimant's December 1990 condition arose.

Dr. Conner described a "large bulbous lesion containing about 30 cc of gold fluid below the previous areas of skin loss in his graft. The area is erythematous. I don't know what happened. He has no sensation here so it is possible that he might have burned it at some time." (Chart note, December 3, 1990). Dr. Conner treated claimant with antibiotics, but the condition worsened to the point that Conner referred claimant to the hospital, where he was treated by Dr. Johnson. Dr. Johnson diagnosed claimant's condition as cellulitis, a purulent infection. (Johnson's notes of December 5, 1990.) After claimant was released back to Dr. Conner's care, Conner again stated, "[Claimant] has first and second degree basic burns on the back of his leg. How he got them I don't know." (Chart note, December 11, 1990.)

Claimant requested own motion claim reopening on January 16, 1991. He also filed a claim with another carrier, who was on the risk at the time of a 1988 industrial injury, for "workers' compensation benefits due to a burn and resulting blister over a skin graft area on the posterior of the right leg sustained on or about December 3, 1990."

In August 1991, claimant's attorney provided Dr. Johnson with a history of claimant's condition that indicated that claimant has had annual outbreaks of skin lesions since the original injury, for which he self-medicated until 1990, when he sought medical attention. The attorney also stated that claimant did not suffer a burn injury to his leg prior to his hospitalization. The attorney requested Dr. Johnson's opinion as to whether it was more probable than not that the 1963 injury is the major contributing cause of claimant's recurrent skin lesions, specifically the one of December 1990.

In response, Dr. Johnson opined that it was probable that the recurrence of claimant's lesions were due to the 1963 injury, "although difficult to say with certainty." (Letter of September 3, 1991 to claimant's attorney.) After the issuance of our September 12, 1991 order, in response to claimant's attorney's question about the relationship of the December 1990 hospitalization to previous injuries, Dr. Johnson responded in relevant part as follows:

> "The hospitalization of March 1964 describes intervention for persistent ulceration of the popliteal area of the right secondary to the initial injury. This ultimately required skin grafting. This describes injuries to leg from the initial injury consisting of

> considerable loss of soft tissues, skin and subcutaneous tissue. At the time of the patient's hospitalization in December of 1990 the patient was experiencing large ulcerated lesions of the right calf with secondary inflammation and infection. There was no injury that the patient was aware of and no reason for the skin breakdown that he could determine. . . . It is my feeling that these two incidents are probably interrelated because the likelihood of developing a scenario such as Mr. Spencer experienced in 1990 would make a normal healthy leg negligible."

Thus, although Dr. Johnson concludes that there was some relationship between claimant's 1963 injury and the December 1990 hospitalization, he did not address the issue of the relative contributions to claimant's 1990 condition of the 1988 injury, the alleged 1990 burn incident, and claimant's diabetes and obesity. Furthermore, it is unclear to us from this record whether claimant suffered a burn in December 1990 and whether Dr. Johnson was given an accurate history of claimant's various conditions.

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, because of the lack of clarity regarding the burn issue and because our questions regarding the relative contributions of the other incidents and conditions remain unanswered, we we are unable to conclude that claimant's December 1990 condition resulted from claimant's 1963 injury. Accordingly, we decline to authorize the payment of medical benefits for claimant's December 1990 condition.

Temporary Disability Compensation

We may authorize, on our own motion, the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(10(a). Here, because we have concluded that there was no worsening of claimant's compensable injury, it follows that we have no authority to award the payment of temporary disability compensation from the date claimant was hospitalized.

We also note that SAIF contends that claimant was not in the work force at the time of his alleged worsening. Claimant contends that he was willing to work and was looking for work. In order to qualify for the payment of temporary disability compensation, claimant must have been in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). Claimant had not worked since he was released from his back injury in June 1990. Therefore, claimant is required to establish that he was willing to work and was looking for work. Although claimant provided a written rendering of an interview at his attorney's office, in which he contended that he had looked for work but the union did not want to place him because of his back injury, he failed to provide evidence supporting that contention. The burden of proof on this issue lies with claimant. Accordingly, we find that claimant was not in the work force at the time of his worsening. See Dawkins, id., and Cutright, id.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRANK L. STEVENS, Claimant
WCB Case No. 91-04675
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Brazeau's order which: (1) upheld the self-insured employer's denial of claimant's aggravation claim for a back condition; (2) upheld the employer's "de facto" denial of claimant's medical services claim for his back condition; and (3) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are aggravation, medical services and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt those portions of the Referee's order concerning the medical services, penalty and attorney fee issues. We supplement that portion of the Referee's order that pertains to the aggravation issue.

The Referee upheld the employer's aggravation denial. In doing so, he concluded that claimant's compensable condition had not worsened since the April 1991 Order on Reconsideration, which the Referee found to be the last arrangement of compensation. The Referee reasoned that the reconsideration date was claimant's last opportunity to present evidence on the issue of the extent of his permanent disability. Although we agree that claimant's aggravation claim is not compensable, we conclude that the Determination Order, not the Order on Reconsideration, was the last arrangement or award of compensation.

We have previously held that the logical point from which to measure claimant's worsening is at his last opportunity to be heard with respect to his condition. Larry H. Erbs, 42 Van Natta 98, 100 (1990). In Erbs, there had been no hearing, but we held that the last arrangement of compensation can be a Determination Order or a stipulated order.

Further, it is conceivable that a worker could worsen subsequent to his last opportunity to present evidence at hearing, but prior to the Referee's issuance of an order. Larry H. Erbs, supra; Joseph R. Klinsky, 35 Van Natta 333, 334 (1983). Therefore, in determining the date of the last award or arrangement of compensation, we reject an approach which could cut off a claimant's aggravation rights during the often-protracted period between claimant's last opportunity to present evidence on his current condition and a final order of the Board or appellate courts establishing claimant's compensation. Joseph R. Klinsky, supra at 333 (1983).

Here, the April 1991 Order on Reconsideration reconsidered claimant's "current condition" as of the date of the December 1990 Determination Order. In doing so, only evidence presented up until the time of the Determination Order was considered. Thus, the Order on Reconsideration is analogous to a final order of the Board or appellate courts concerning a record that was developed at hearing. See Larry H. Erbs, supra; Joseph R. Klinsky, supra. Accordingly, we conclude that the December 1990 Determination Order, which the April 1991 order

reconsidered, was claimant's last opportunity to present evidence of his current condition. Therefore, the December 1990 Determination Order was the last arrangement or award of compensation.

We proceed to a determination of whether claimant's compensable condition has worsened since December 28, 1990, the date of his last award or arrangement of compensation. Claimant contends that his compensable condition worsened in the period between the December 1990 Determination Order and the April 1991 Order on Reconsideration. (App. Br. at 5; Reply at 2). We disagree with claimant's contention.

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are persuasive reasons not to defer to Dr. Stevens' opinion.

Dr. Stevens, M.D., who first began treating claimant in February 1991, does not support claimant's contention that his condition worsened between December 1990 and April 1991. Specifically, Dr. Stevens concluded that claimant's subjective complaints of pain and difficulty in walking, standing and sitting had worsened since he was last examined for the closing of his initial claim on November 9, 1990. (Ex. 64).

To begin, because Stevens did not have the opportunity to examine claimant before the December 1990 closure, Stevens did not have the advantage of comparing claimant's condition before and after his alleged aggravation. Furthermore, Dr. Stevens did not discuss claimant's well-documented pain behavior, functional overlay and exaggeration of symptoms. Lacking such a discussion, we do not consider Stevens' opinion to be persuasive. Miller v. Granite Construction Co., 28 Or App 473 (1977).

Moreover, the Referee found claimant at hearing to be somewhat histrionic and believed he exaggerated his disability. Surveillance film shown at hearing contradicted claimant's testimony as to his ability to perform various tasks. Thus, the Referee found, and we agree, that claimant's subjective complaints to his doctors were rendered unreliable in light of this information. Miller v. Granite Construction Co., supra.

As we have discounted Dr. Stevens' opinion, we are left with two other medical opinions in the record. Neither opinion addresses the question of whether claimant's compensable condition worsened within the period in dispute.

On March 27, 1991, the Western Medical Consultants performed an independent medical examination. (Ex. 66). Noting that claimant had excellent strength and no evidence of any neurological deficits, the Consultants concluded that the physical examination did not mesh with claimant's stated complaints of pain. (Ex. 66). Such a conclusion does not support claimant's contention. Rather, if anything, the Consultants' reference to an inconsistency between claimant's subjective complaints and objective findings supports the Referee's finding that claimant's testimony and history were not reliable.

On April 17, 1991, claimant was examined by Dr. Holzapfel, chiropractor. (Ex. 68). Dr. Holzapfel merely noted that claimant continues to suffer residual low back pain and lower extremity changes as a result of his industrial injury. (Id). As with the Consultants, Holzapfel does not address the pivotal worsening question. Moreover, since Holzapfel's findings are attributable to claimant's subjective complaints, they are similarly unreliable.

Inasmuch as the record lacks persuasive medical evidence that claimant's compensable condition worsened between December 1990 and April 29, 1991, we conclude that he has not established an aggravation during the period asserted by claimant. Consequently, we agree with the Referee that the employer's denial should be upheld.

ORDER

The Referee's order dated August 9, 1991 is affirmed.

In the Matter of the Compensation of
THERESA F. TRAHAN, Claimant
WCB Case No. 88-17678
ORDER DENYING RECONSIDERATION
Garry L. Kahn, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant, pro se, has submitted a letter "to see if I could appeal this myself or get another lawyer." Considering that a September 11, 1990 Board order affirmed a Referee's order upholding the insurer's denial of claimant's left wrist scapho-lunate ligament tear claim, we treat claimant's letter as a motion for reconsideration or republication of the Board order. Inasmuch as we find that our prior order has become final, we conclude that we lack authority to reconsider or republish our order.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (1990). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(20).

When an order has been mailed to a party at an address other than that previously provided to the forum, the order has not been mailed to a party and is not final. Ernest L. Vaughn, 40 Van Natta 1574 (1988); Douglas Meuler, 40 Van Natta 989 (1988); compare Joyce E. Mitts, 42 Van Natta 972 (1990) (Where the current address of a party had been provided to the Hearings Division in another case, but not to the Board in the case in question, and a copy of the Board's order in the case in question, which was mailed to that party at the address provided to the Board in the case in question, was not returned as undeliverable, the Board held that its order had been mailed to all parties and was final.)

Here, claimant asserts that the Workers' Compensation Ombudsman provided her with "a copy of my appeals" and that she has "found out that [her] claim could have been appealed." Contending that she has been "falsely represented by [her] attorney," claimant inquires as to whether she "could appeal this myself or get another lawyer."

Claimant's decision regarding whether to petition for judicial review of the Board's September 11, 1990 order or to secure new legal representation are questions that are entirely personal choices which are not subject to our authority. Consequently, we will not comment on those options.

Nevertheless, those portions of claimant's letter which suggest that she only recently learned that her claim could have been appealed can be interpreted as a contention that she did not receive a copy of the Board's September 11, 1990 order. Based on such an interpretation, we have reviewed this matter to determine whether the aforementioned order can be republished.

To prompt the reissuance of our September 11, 1990 order, claimant must establish that a copy of the order was not mailed to her. Berliner v. Weyerhaeuser Company, supra. The record does not support such a finding.

To begin, the Board's order and file indicate that copies of the order were mailed to all parties, as well as their representatives. Moreover, the record does not contain a copy of the Board's order marked undeliverable by the postal service. We further note that the return address listed on the envelope which contained claimant's recent letter is the same address listed for claimant on the Board's September 11, 1990 order; i.e, "5824 NE 42nd Ave, Portland, OR 97218." Such circumstances persuade us that copies of the Board's September 11, 1990 order were mailed to all parties to the proceeding.

It is unfortunate if claimant did not receive a copy of the Board's order. It is also regrettable if claimant was unaware that she could appeal the order as a result of her legal representation. However, such circumstances do not provide authorization for the reissuance of our September 11, 1990 order.

In conclusion, based on the aforementioned reasoning, we find that a copy of our September 11, 1990 order was mailed to claimant and all other parties to the proceeding. Inasmuch as our order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, it has become final. ORS 656.295(8); International Paper v. Wright, supra; Fischer v. SAIF, supra. Consequently, we are without authority to republish our order as claimant apparently requests.

Accordingly, the request for reconsideration or republication of our September 11, 1990 order is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
DALE A. WILSON, Claimant
WCB Case No. C1-102534
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Emmons, Kropp, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

On November 26, 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.

The submitted agreement provides that the parties agree to settle the claim for a total of $8,250. The summary sheet provides that, out of the $8,250 total, claimant's counsel shall be paid an attorney fee in the amount of $2,062.50. The agreement itself has been revised to provide that, out of the total consideration amount of $8,250, $6,250 shall be paid to claimant and $2,000 shall be paid to claimant's counsel.

Although the summary sheet has not been revised to reflect the changes made within the agreement itself, we find that it is the parties' intent to provide that, from the total proceeds, claimant is to be paid $6,250 and claimant's counsel is to be paid an attorney fee in the amount of $2,000. Because the total amounts provided upon the summary sheet and within the agreement are consistent and we find the parties have merely revised the agreement to provide for a lower attorney fee with an increased amount of consideration to be paid to claimant, we find the omitted revision upon the summary sheet to constitute an inadvertent error. Therefore, we approve the proposed agreement.

This agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. A $2,000 attorney fee payable to claimant's attorney according to the terms of this agreement is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARVIN W. BELQUIST, Claimant
WCB Case No. 90-10115
ORDER ON REVIEW
Silven, Schmeits, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Leahy's order which upheld the insurer's denial of his injury claim for an acne condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

ULTIMATE FINDINGS OF FACT

The 1990 amendments to the Workers' Compensation Act apply to this case.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990. Although a hearing was not convened, the hearing in this matter was set for November 6, 1990. The parties agreed that the case would be removed from the docket and decided on the documentary record alone. Therefore, the

"litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990. In doing so, we reject claimant's argument that application of the amended law to his claim is unconstitutional. See Borisoff v. Workers' Compensation Board, 104 Or App 603 (1990).

Compensability

The Referee concluded that claimant's acne condition was properly characterized as a "consequence" of a compensable injury, and that claimant had not proven his 1979 injury, which rendered him paraplegic, was the major contributing cause of this condition. See amended ORS 656.005(7)(a)(A).

Subsequent to the date of the Referee's order we held that the 1990 amendments do not affect the standard of compensability for conditions which result directly from the industrial accident; only the level of proof required for compensability of conditions which arise as a consequence of the compensable condition has been changed to the major contributing standard. Julie K. Gasperino, 43 Van Natta 1151, 1153 (1991). In Gasperino, we concluded that the question of whether or not a condition arose directly from the accident itself or secondary as a consequence of the compensable condition sustained in the accident was a question of medical cause and effect which must be determined on a case by case basis.

Claimant's compensable injury occurred in 1979. The acne and dermatitis conditions did not arise until several years after the injury. Claimant asserts that his current acne and dermatitis conditions result from the paraplegia caused by the 1979 injury. Under the circumstances presented by this case, we conclude that claimant's acne condition is a secondary as opposed to a primary consequential condition of his 1979 compensable injury. See Julie K. Gasperino, supra.

This case presents a complex medical question of the causation of claimant's acne condition. We require expert medical opinion to resolve the issue presented. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). The record contains two opinions on the causation of claimant's acne condition. Dr. Miller is a dermatologist who treated claimant for the acne and dermatitis conditions. He opined that the acne and dermatitis conditions "may have been, at least, partially aggravated by the fact that [claimant] is a paraplegic." Claimant's family physician, Dr. Price, also gave an opinion on causation. He stated that "the combination of stress, fatigue, and immobility that result from his paraplegia have led to and aggravated" claimant's dermatitis.

Because of his greater expertise in the treatment of skin diseases, we defer to dermatologist, Dr. Miller. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Dr. Miller does not indicate that the 1979 injury is the major contributing cause of claimant's acne and dermatitis conditions. In fact, Dr. Miller's statement that claimant's acne "may have been" aggravated by claimant's paraplegia connotes a mere possibility of a causal connection between claimant's paraplegia and his acne condition. The law requires more than the possibility of a causal connection between the injury and the acne condition. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Accordingly, we find that claimant has not met his burden of proof to show that the 1979 injury was the major contributing cause of his acne and dermatitis conditions.

ORDER

The Referee's order dated April 5, 1991 is affirmed.

January 15, 1992 Cite as 44 Van Natta 66 (1992)

In the Matter of the Compensation of
MERRILL L. CHICHA, Claimant
WCB Case No. 90-13774
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Mills' order which set aside its partial denial of claimant's medical services claim for his psychiatric condition. On review, the insurer contends claimant's psychiatric treatment is not compensable as a necessary prerequisite to claimant's recovery from surgery for his compensable shoulder condition because the need for psychiatric treatment was the result of a drug-induced psychosis unrelated to claimant's compensable condition. We affirm.

FINDINGS OF FACT

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

The insurer's denial of claimant's psychiatric treatment issued on June 18, 1990.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch. 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Medical Services

Claimant requested a hearing pursuant to ORS 656.319, challenging the insurer's June 18, 1990 partial denial of his psychiatric treatment. The Referee found that claimant's need for psychiatric treatment was not drug-related and was necessary to permit treatment of claimant's compensable shoulder injury. On review, the insurer contends that claimant's need for these services was caused

by drug use and, therefore, the services are not compensable under ORS 656.005(7)(b)(C). We disagree.

Assuming without deciding that ORS 656.005(7)(b)(C) applies to medical services, the record does not establish by clear and convincing evidence that claimant's need for psychiatric services was drug-related. Claimant suffered a compensable shoulder injury on September 27, 1989 and underwent surgery on his shoulder on December 29. 1989. (Ex. 4 and 10-4). He started having psychiatric problems in January 1990, about two weeks after the surgery, and was referred to Dr. Gross for psychiatric treatment. (Ex. 10-7 and 26). While claimant admitted to using drugs during July and August of 1990 (Tr. 100 and 129), there is no evidence that he was taking drugs in January 1990 when his psychiatric problems started.

On this record, we concur with the Referee's finding and conclude that claimant is entitled to payment for psychiatric services which are required to permit treatment of his compensable shoulder condition. ORS 656.245; see SAIF v. Roam, 109 Or App 169 (1991).

Attorney Fee Award

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under 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 is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 3, 1990 is affirmed. For services rendered on review, claimant's attorney is awarded $1,000, to be paid by the insurer.

January 15, 1992 Cite as 44 Van Natta 67 (1992)

In the Matter of the Compensation of
MARY A. HOLMES-NOFFSINGER, Claimant
WCB Case No. 90-10340
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Gruber's order that: (1) upheld the insurer's denial of claimant's organic brain disorder claim; (2) declined to award interim compensation; and (3) declined to assess penalties and attorney fees for an allegedly unreasonable denial and failure to pay interim compensation. On review, the issues are compensability, interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following corrections and supplementation. We replace the third sentence of the first paragraph with the

following. Claimant was knocked to the ground as a result of the work injury, but it is not clear whether she lost consciousness. We eliminate the word "first" in the first sentence of the fourth paragraph.

On March 17, 1987, Dr. Patterson, neurologist, noted that claimant had some visual blurring and vague dizziness over the past few weeks which claimant attributed to poor eating habits. (Ex. 5).

On January 9, 1988, claimant reported that she experienced dizziness if she did not take her sinus medication. (Ex. 14A).

On July 30, 1990, claimant was examined by Dr. Harris, neurologist. Claimant reported that she hit her head, but did not lose consciousness during the February 6, 1988 auto accident. (Ex. 48-2).

ULTIMATE FINDINGS OF FACT

We adopt the Referee's ultimate findings of fact with the following supplementation. Claimant was not entitled to interim compensation prior to the insurer's August 2, 1990 denial.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant failed to establish that her January 1987 work injury was either a material or a major contributing cause of her cognitive brain dysfunction. We find that the standard of proof in this case is a material contributing cause and agree with the Referee that claimant has failed to meet that standard.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Citing ORS 656.005(7)(a)(A), the insurer argues that claimant must prove that the work injury was the major contributing cause of the organic brain disorder. Claimant contends that as a direct result of the January 1987 industrial accident, she suffered an organic brain disorder (post concussion syndrome), although that disorder was not diagnosed until April 1990. Thus, claimant argues, to establish compensability of this condition she must prove that the work injury was a material contributing cause of her brain disorder. We agree with claimant's statement of the law. The standard of compensability for an initial industrial injury claim remains material contributing cause. Mark N. Weidle, 43 Van Natta 855 (1991); see also Julie K. Gasperino, 43 Van Natta 1151 (1991). However, on this record, claimant has not established that the January 1987 work injury is a material contributing cause of her organic brain disorder.

Claimant sustained possible head injuries both during the 1987 work injury and the 1988 noncompensable auto accident. Furthermore, the medical experts on both sides of the question agree that claimant's loss of cognitive ability (particularily memory loss) is significantly effected by non-compensable

psychogenic factors. Therefore, the issues of whether claimant has a neurological disorder, and if so, whether the condition is compensably related to her industrial injury are complex medical questions. Thus, although claimant's testimony is probative, the resolution of these issues 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).

Because claimant sustained possible head injuries both during the 1987 work injury and the 1988 noncompensable auto accident, the accuracy of the histories claimant gave to the various physicians regarding these incidents and the timing of her reports of cognitive problems is crucial to evaluating the medical reports.

Claimant's reports to the treating and examining physicians about the severity and effects of the auto accident varied. In the February 6, 1988 emergency room report following claimant's auto accident, the nurse noted that claimant "denies LOC [loss of consciousness]" and the doctor noted "? brief LOC." (Ex. 16A). On May 10, 1988, claimant reported to Dr. Byers, M.D., that she hit her head on the windshield and lost consciousness from five to ten minutes. (Ex. 26-1). Dr. Carter, treating psychiatrist, noted that claimant minimized the auto accident, stating that she experienced no significant injury. (Ex. 47-1). On July 30, 1990, claimant reported to Dr. Harris, consulting neurologist, that she hit her head during the auto accident, but did not lose consciousness. (Ex. 48-2).

The record also indicates that claimant did not report cognitive problems in the form of memory loss until after the auto accident. During a psychological evaluation on August 14, 1987, Dr. Wicher, a psychologist with the Northwest Pain Center, noted that: (1) claimant's thought processes appeared to be well intact; (2) her speech patterns appeared to be reasonable and consistent with her educational and cultural background; and (3) she presented no indications of memory or concentration difficulties. (Ex. 11-3).

However, on July 30, 1990, claimant reported to Dr. Harris that: (1) her main problem was the change in her memory; (2) she used to have a photographic memory; (3) she had had memory problems since her January 1987 work injury; and (4) there had been no worsening or progression of her memory problems over the last three years. (Ex. 48-1). Claimant reported to Dr. Kurlychek, neurophysiologist, and Dr. Carter that her cognitive problems dated back to the work injury. (Exs. 38-8, 47-1).

Furthermore, the record indicates noncompensable psychological factors influenced claimant's cognitive symptomatology. The Northwest Pain Center diagnosed: (1) somatization of stress and tension; (2) psychogenic magnification of pain; and (3) reduced incentive for reduction of pain behavior due to secondary gain. (Exs. 11-4, 13-1, 13-2, 17-6, 41-10). Dr. Kurlychek diagnosed psychogenic factors contributing to claimant's neuropsychological deficits. (38-8).

Claimant argues that a report from Dr. Carter, treating psychiatrist, establishes that claimant's cognitive problems were not the result of non-neurological, psychological processes. We disagree.

On June 25, 1990, Dr. Carter diagnosed post-concussion phenomena and "an adjustment disorder with some magnification of physical complaints on a psychophysiologic basis relative to her injury of 1/18/87." (Ex. 47-3). On September 18, 1990, Dr. Carter agreed with the Northwest Pain Center's recommendation that "the most effective way to evaluate neurological versus non-

neurological contributions to [claimant's] cognitive impairment would be through an extended behavioral and psychological evaluation at a head trauma treatment program." (Ex. 53-2). On October 3, 1990, Dr. Carter concluded that claimant's cognitive problems did not reflect non-neurological, psychological processes. (Ex. 54-1). The fact that claimant did not undergo an evaluation at a head trauma treatment program, which Dr. Carter agreed would disclose the presence of any non-neurological contribution, makes Dr. Carter's final opinion that there is no non-neurological contribution unpersuasive. For the same reason, we must question the validity of the Pain Center's contrary opinion that claimant's symptoms were solely the result of psychogenic factors. Thus, in effect, the medical evidence on the question of whether claimant actually has a brain disorder is in equipoise.

We rely on medical opinions which are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Furthermore, an opinion based on inaccurate history is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, 64 Or App 810 (1983). Because claimant's reports as to the effect of the auto accident and the timing of the cognitive problems varied significantly, we are unable to determine which physician had an accurate history upon which to base his opinion. Accordingly, we conclude that claimant has failed to prove that she has a cognitive brain disorder which was materially caused by the 1987 work injury.

Interim Compensation

The Referee found that claimant was not entitled to interim compensation because Dr. Kurlychek's report did not provide medical verification of an inability to work. On review, claimant concedes this fact in relation to Dr. Kurlychek's report but contends that a report from Dr. Carter established the required medical verification of inability to work.

The insurer argues that, under amended ORS 656.273(6), no interim compensation is due unless the claim is compensable. We rejected that argument in Doris A. Pace, 43 Van Natta 2526 (November 18, 1991). There, we concluded that ORS 656.273(6) required the insurer to pay claimant interim compensation no later than the 14th day after it received medical verification of an inability to work as documented in a medical report which constitutes prima facie evidence of a compensable worsening. Thereafter, interim compensation continues until a formal denial of the claim is issued. ORS 656.262(4); Bono v. SAIF, 298 Or 405 (1984); Roger G. Prusak, 40 Van Natta 2037 (1988).

Here, Dr. Carter submitted an 827 form which released claimant from work and indicated that she was not medically stationary. (Ex. 44). The insurer received this report on June 16, 1990. However, this form did not constitute prima facie evidence of a compensable worsening because Dr. Carter did not relate claimant's condition to the compensable condition. On August 2, 1990, the insurer denied claimant's cognitive brain disorder claim. (Ex. 49). On August 20, 1990, the insurer received a report from Dr. Carter that related claimant's condition to the compensable injury. (Ex. 45). Because the insurer issued a formal denial before it had the notice or knowledge statutorily required to trigger its duty to pay interim compensation, we conclude that claimant is not entitled to interim compensation.

Penalties and Attorney Fees

Claimant argues that she is entitled to penalties and attorney fees because the insurer's denial of her cognitive brain disorder was unreasonable. However, we have found that claimant has not established that her cognitive brain disorder is compensable. Therefore, she is not entitled to penalties or

attorney fees on that issue. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

Claimant also argues that she is entitled to a penalty under ORS 656.262(10) and an attorney fee under ORS 656.382(1) for the insurer's refusal to pay interim compensation. Because we have found that the insurer was not obligated to pay claimant interim compensation, we also find that the insurer's failure to pay said compensation is not unreasonable. Accordingly, claimant is not entitled to penalties or attorney fees on that issue.

ORDER

The Referee's order dated January 22, 1991 is affirmed.

January 16, 1992 Cite as 44 Van Natta 71 (1992)

In the Matter of the Compensation of
LINDA R. BURROW, Claimant
WCB Case No. 90-21508
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
C. Douglas Oliver, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Leahy's order that set aside its denial of claimant's cervical condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions and reasoning concerning the compensability issue with the following supplementation.

In its denial, and at hearing, SAIF contended that claimant's cervical condition was not compensable on the basis that her accepted injury was not the major contributing cause of her cervical condition. On review, SAIF advances, for the first time, the contention that claimant was acting as a "volunteer" at the time of the June 1990 incident; therefore her cervical condition is not compensable on the basis that it did not occur in the course and scope of her employment. Claimant submits that SAIF cannot raise this theory, for the first time, at Board level. We agree.

SAIF's position could be characterized as merely a different theory on the question of compensability, rather than a separate and new defense. However, we conclude that claimant would be prejudiced if we resolved this case on a course and scope basis. Claimant's evidentiary showing at the hearing addressed the causal relationship between the compensable injury and her cervical condition. This was consistent with SAIF's denial and characterization of the issue at the time of hearing. To now decide this case on a completely different basis would be fundamentally unfair, and we decline to do so. See Mavis v. SAIF, 45 Or App 1059 (1980); Karen K. Malsom, 42 Van Natta 503 (1990) (improper for Board to

address "worsening" issue when causal relationship question was only issue litigated at hearing regarding aggravation denial); Gunther H. Jacobi, 41 Van Natta 1031 (1989).

Even if we were to address this issue, we would find SAIF's contention completely without merit, even as the record stands. There is no dispute that the June 1990 incident occurred at work and that claimant was injured while assisting a co-worker who was being attacked by a patient. Claimant was paid for her activity, which obviously benefited her employer, in that a violent patient was restrained and a fellow employee was protected from harm by claimant's intervention. Although given the employer's instruction to refrain from "strenuous" activity, the employer probably had a right to take exception to the manner and method of claimant's work performance during the incident, claimant was performing work for the employer. She was clearly not a "volunteer."

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the compensability issue is $1,000, to be paid by the SAIF Corporation. 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 March 7, 1991 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
PAMELA R. CRAIN, Deceased, Claimant
WCB Case No. 90-15903
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Susan B. Ebner (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant's beneficiaries request review of Referee Podnar's order which affirmed a Determination Order that did not award any permanent disability for a right shoulder injury. On review, the issue is extent of permanent disability. We affirm.

FINDINGS OF FACTS

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

At the time of claimant's death from a noncompensable motor vehicle accident, further material improvement would reasonably be expected for claimant's compensable right shoulder condition from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

Reasoning that claimant's condition was not medically stationary and considering the speculative nature of the factors necessary to determine claimant's permanent disability (such as her adaptability and impairment), the Referee concluded that claimant was not entitled to permanent disability rating at the time of her death. Inasmuch as claimant would not have been entitled to a permanent disability award, the Referee held that claimant's beneficiaries were likewise not entitled to recover any benefits. See ORS 656.218(1). We agree, but for the following reasons.

A deceased worker's beneficiaries are entitled to recover the worker's benefits. Jeannie E. Spunaugle (Deceased), 42 Van Natta 2546, 2547 (1990). However, in order for the beneficiaries to recover such benefits, the deceased worker must have been entitled to the benefits. ORS 656.218(1); Spunaugle, supra. When the record supports a finding that a deceased claimant's compensable condition was medically stationary prior to the claimant's death, an award of permanent disability may be granted based upon medical evidence establishing the claimant's permanent impairment. Carl L. Stevens, 43 Van Natta 2700 (1991).

An injured worker is considered medically stationary when no further material improvement of the compensable condition would reasonably be expected from medical treatment or the passage of time. See ORS 656.005(17). The resolution of the medically stationary date is primarily a medical question. Harmon v. SAIF, 54 Or App 121, 125 (1984).

After consideration of the medical evidence, we are not persuaded that claimant's compensable right shoulder condition was medically stationary at the time of her death. We base this conclusion on the following findings.

On October 2, 1989, Dr. Brenneke, orthopedist, diagnosed a ligament tear in claimant's right shoulder, which would need surgery to repair. Noting that such a procedure required "a significant commitment" from claimant, Brenneke recommended that claimant undergo an intensive physical therapy program before proceeding with the surgery. In November 1989, Dr. Switlyk, M.D., agreed that a physical therapy program was "very reasonable and important" for the strengthening of claimant's shoulder.

Due to "multiple difficulties following through with Dr. Brenneke," claimant did not undergo physical therapy. On February 7, 1990, claimant came under the care of Dr. Helton, chiropractor. Concluding that claimant's condition was not medically stationary, Helton prescribed conservative treatment. Dr. Helton anticipated "some observable result, both subjectively and objectively, within one month."

On March 7, 1990, the Western Medical Consultants performed an independent medical examination. The Consultants found "no contraindication" to Dr. Brenneke's surgery recommendation. Stating that "'time' was probably the best treatment available," the Consultants concluded that claimant's condition was not medically stationary. Finally, the Consultants recommended that claimant avoid chiropractic treatment.

On April 18, 1990, Dr. Helton reported that claimant was responding "quite favorably thus far to treatment." Concluding that swimming would "help in her reconditioning and rehabilitation," Helton anticipated that claimant would need six months of "gradual rehabilitation involving the swimming." On April 26, 1990, claimant was killed in a noncompensable motor vehicle accident.

On November 12, 1990, Dr. Barth, neurologist, of the Western Medical Consultants concluded that he had been unable to provide an accurate assessment of claimant's permanent impairment during her March 1990 examination. Barth reached such a conclusion because claimant's condition was not medically stationary at that time.

On November 19, 1990, Dr. Helton opined that claimant would have had "some permanent partial impairment" as a result of her compensable injury. Helton anticipated "some degree of loss of strength due to the instability in her shoulder." Had surgery been performed, Helton forecasted "some degree of impairment, either a loss of range of motion or loss of strength."

On November 28, 1990, Dr. Wade, claimant's prior treating orthopedist, surmised that claimant was "stable and unchanging at the time of her fatal accident." In making such a statement, Wade acknowledged his uncertainty as to its accuracy because he had last examined claimant in 1988.

In December 1990, Dr. Norton, M.D., reviewed claimant's medical file. Norton reported that several examinations demonstrated no passive or active loss of shoulder motion. Noting that the loss of motion was attributed to claimant's pain, Norton opined that any loss of motion should be ascribed to a "chronic condition." Diagnosing "mild shoulder instability," Norton rated claimant's shoulder impairment at "no more than 5% for a chronic condition."

At the time of claimant's April 26, 1990 death, no physician had considered her shoulder condition to have reached a medically stationary status. In fact, approximately one month before her death, the Northwest Medical Consultants had expressly stated that her condition was not medically stationary. Moreover, one week prior to claimant's death, her treating chiropractor, Dr. Helton, had recommended that claimant participate in swimming activities for reconditioning and rehabilitation. Inasmuch as Helton had not considered claimant's condition to be medically stationary some two months before this swimming recommendation, we do not consider this opinion to be persuasive evidence that claimant's condition was medically stationary at that time. Finally, since Dr. Wade conceded that he had not examined claimant since 1988, we do not find his opinion that her condition was "stable and unchanging" at the time of her death to be persuasive.

Consequently, the medical evidence does not support the conclusion that claimant's compensable right shoulder condition was medically stationary at the time of her April 26, 1990 death. Inasmuch as claimant's condition was not medically stationary, it would be entirely speculative for us to determine claimant's capacity to return to work or the extent of her permanent impairment attributable to her compensable condition. See Jeannie E. Spunaugle, supra.

Finally, even if claimant's compensable condition was medically stationary at the time of her death, her beneficiaries would not be entitled to recover a permanent disability award. No award of unscheduled permanent disability shall be allowed if a claimant has not suffered measurable impairment. Former OAR 436-35-270(2). Impairment means a decrease in the function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, copyright 1984. Former OAR 436-35-005(1).

Claimant's beneficiaries contend that impairment has been established through the reports issued by Dr. Helton, the Western Medical Consultants and Dr. Norton. Specifically, the beneficiaries assert that: (1) Helton stated that claimant would have "some" impairment with or without surgery; (2) the Consultants reported that claimant would have "significant impairment and

residuals"; and (3) Norton rated claimant's impairment at 5 percent due to a chronic condition.

To begin, in light of the speculative nature of these opinions, we do not consider them to be particularly persuasive. In any event, none of these opinions establishes entitlement to a permanent disability award under the "standards." References to "some" and "significant" do not suggest that the physician's assessments of claimant's "impairment" was based on measurements according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment.

Furthermore, in order to receive an award for a chronic condition limiting repetitive use of a body part, a claimant must have suffered "impairment" as defined by the "standards." William K. Nesvold, 43 Van Natta 2767 (1991). Therefore, because the record does not support a finding that claimant suffered "impairment" under the "standards," an award based on Dr. Norton's "chronic condition" rating is unavailable.

In conclusion, because claimant's compensable condition was not medically stationary at the time of her death, we hold that any assessment of her permanent impairment would be entirely speculative and unpersuasive. Therefore, claimant would not be entitled to a permanent disability award. Under such circumstances, claimant's beneficiaries are likewise not entitled to recover any permanent disability award. Alternatively, even if claimant's compensable condition was medically stationary at her death, we are not persuaded that she suffered measurable impairment under the "standards." Since such a conclusion would be necessary to an award of permanent disability under the "standards," neither claimant nor her beneficiaries could recover such an award.

ORDER

The Referee's order dated March 7, 1991 is affirmed.

January 16, 1992 Cite as 44 Van Natta 75 (1992)

In the Matter of the Compensation of
DIANE T. DAWES, Claimant
WCB Case No. TP-91021
THIRD PARTY DISTRIBUTION ORDER
Olson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Safeway Stores, Inc., as a paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of settlement proceeds stemming from a malpractice action against claimant's former attending physician. See ORS 656.593(3). Contending that the record does not support a conclusion that the paying agency incurred additional expenses as a result of the malpractice, claimant asserts that Safeway is not entitled to a share of the settlement proceeds. We agree with claimant's contention.

FINDINGS OF FACT

In April 1988, claimant, a fish cutter apprentice, filed a bilateral carpal tunnel syndrome claim. Safeway accepted the claim and provided compensation. Following surgery on both wrists, claimant returned to work. When her symptoms continued, claimant left her employment. Her claim was reopened in October 1988.

Claimant came under the care of Dr. Jewell, hand surgeon. Diagnosing ongoing upper extremity symptomatology associated with carpal tunnel syndrome, Jewell recommended medication and physical therapy.

In March 1989, Dr. Jewell recommended that claimant be referred to a pain center. As an interim measure, Jewell prescribed further medication. In April 1989, when claimant's symptoms remained unchanged, Jewell repeated his recommendation for a pain center referral. As a further interim measure, Jewell referred claimant to Dr. Meece, chiropractor, for "upper extremity chiropractic care concerning her myofascial symptomatology."

Claimant began receiving treatments from Dr. Meece on April 13, 1989. These treatments, which continued through July 12, 1989, also included low back and coccyx manipulations.

On May 18, 1989, with Dr. Jewell's approval, claimant was evaluated by the Salem Hospital physical medicine and rehabilitation center. Rather than recommending a pain clinic referral, Dr. Chester of Salem Hospital suggested that claimant be referred to a work hardening program for a physical capacity assessment.

On June 22, 1989, a physical capacities evaluation was conducted by the Industrial Medicine section of Salem Hospital. Claimant demonstrated the physical capacity to perform sedentary work and to lift/carry 15 pounds occasionally.

On June 30, 1989, claimant returned to Dr. Jewell for a follow-up visit. Noting that claimant had completed a portion of her physical capacities evaluation and was continuing to receive therapy from Dr. Meece, Jewell diagnosed "[i]mproving upper extremity symptomatology." After reviewing Dr. Chester's report, Jewell recommended that claimant pursue a work hardening program. In addition, Dr. Jewell also suggested that repeat nerve conduction testing be conducted.

On July 5, 1989, Dr. Jewell reiterated his agreement with Dr. Chester's recommendation for a work hardening program. Noting that the repeat nerve conduction testing remained pending, Jewell also concluded that Dr. Meece's treatments for claimant's upper extremity condition were appropriate.

On July 12, 1989, Dr. Meece reported that claimant would be relocating at the end of the month. Since she wished to continue with her therapy, Meece recommended a referral to a physician in the area to which claimant was moving.

On July 17, 1989, Dr. Jewell reported that claimant's nerve conduction studies were normal. Inasmuch as claimant's wrist pain and tenderness continued, Jewell prescribed "nocturnal splinting."

On July 27, 1989, Salem Hospital advised claimant that she was scheduled to begin participating in the "Industrial Medicine Program" on August 7, 1989. The following day, Dr. Jewell referred claimant to Dr. Knox, neurologist.

On July 31, 1989, Dr. Jewell reported that claimant was, "for the most part, medically stationary." Concluding that claimant was experiencing some mild upper extremity problems, Jewell recommended that claimant be referred to a hand therapist for a closing evaluation. Reiterating that claimant had been referred to Dr. Meece for upper extremity symptoms, Jewell did not know why Meece had been adjusting claimant's back.

On September 6, 1989, claimant completed a physical capacity evaluation conducted by Dr. Chester. Finding that claimant's condition was medically

stationary and that she was capable of light duty work, Chester recommended claim closure. On September 28, 1989, Dr. Jewell agreed that claim closure was "definitely indicated."

On October 12, 1989, Dr. Cohen, orthopedist, performed an independent medical examination. Noting that most of claimant's symptoms were somatic, Cohen suggested that a rehabilitation program be considered. Cohen further concluded that the "[t]he most important thing . . . is that the claim should be closed with some disability rating." Dr. Jewell again concurred that claim closure was indicated.

On October 24, 1989, claimant was examined by Dr. Knox. Thereafter, Knox learned that Dr. Meece's treatments had included coccyx manipulations. Diagnosing "[a]lleged trauma to the coccyx with coccydynia," Knox did not consider the manipulations to be related to claimant's compensable upper extremity condition. Knox referred claimant to Dr. Hart, obstetrician/gynecologist, who diagnosed a coccygeal bruise. Claimant also received psychiatric counseling for her "post traumatic stress reaction" to the coccyx manipulations.

A November 13, 1989 Determination Order closed claimant's claim. Claimant was awarded temporary total disability through October 12, 1989. In addition, claimant was granted 27 percent scheduled permanent disability for each of her forearms. This Determination Order award was reduced to 5 percent scheduled permanent disability by a January 4, 1990 Determination Order.

In August 1990, claimant filed a malpractice action against Dr. Meece. The complaint alleged that Meece performed unnecessary adjustments to claimant's low back and coccyx, areas which claimant was not experiencing symptoms prior to the treatments. Claimant sought approximately $4,000 in medical expenses and unspecified non-economic damages.

Prior to trial, claimant settled her lawsuit with Dr. Meece for $80,000. Claimant and Safeway agreed that claimant's counsel would hold in trust a portion of the settlement proceeds equal to the amount of Safeway's asserted lien ($2,018.78). The parties further agreed that they would submit their dispute to the Board for resolution.

From April 17, 1989 through June 28, 1989, Dr. Meece submitted chiropractic bills to Safeway. According to the billing statements, Meece's bills were for treatments provided for claimant's "bilateral upper extremity." Safeway paid these bills, as well as provided temporary disability benefits during this period. Safeway's $2,018.78 lien is composed of $655.92 in Dr. Meece's medical bills and $1,352.86 in temporary disability benefits paid "during the period of treatment with Dr. Meece (April 17, 1989 through July [sic] 28, 1989)."

CONCLUSIONS OF LAW

A paying agency is entitled to the recovery of its claim costs from a third party settlement for malpractice to the extent that the agency is receiving reimbursement for additional expenses incurred as a result of the malpractice. Ray F. Littlefield, 41 Van Natta 1781 (1989); John Galanopoulos, 34 Van Natta 615, 616 (1982). The burden of proof is upon the paying agency to establish the extent of expenditures attributable to the malpractice. Id.

Here, Safeway contends that it is entitled to recover from the third party settlement its costs incurred in paying Dr. Meece's chiropractic bills for "improper treatments" and in providing temporary disability between April 17, 1989 and July 28, 1989 (the dates which Safeway asserts that claimant was under

Dr. Meece's care - we note parenthetically that the record indicates that Dr. Meece provided treatments to claimant from April 17, 1989 through June 28, 1989). Specifically, Safeway argues that Dr. Meece's "improper 'treatments' prejudiced employer by requiring employer to pay additional time loss and medical services for 'care' which physically and mentally damaged claimant."

The record does not establish that the compensation for which Safeway is seeking reimbursement would not have been incurred but for the malpractice. To begin, Dr. Meece provided chiropractic treatments on referral from claimant's former treating physician, Dr. Jewell. This referral was designed as an "interim measure" for claimant's upper extremity symptomatology. Dr. Meece's chart notes refer to coccyx adjustments on two occasions. Nevertheless, Meece's billings did not mention any low back or coccyx treatment. Rather, the billing statements were for treatments concerning claimant's "bilateral upper extremity."

Furthermore, while claimant was receiving treatments from Dr. Meece, she continued to occasionally see Dr. Jewell, as well as undergo physical capacity evaluations and a nerve conduction study. These examinations and evaluations continued to document ongoing, but improving, symptomatology in claimant's wrists. Dr. Jewell also did not mention that claimant's condition was nearing a medically stationary status until July 31, 1989. At that time, following a normal nerve conduction study and a referral to Dr. Knox, neurologist, Jewell recommended a closing evaluation. Finally, Jewell concluded that Dr. Meece's treatments for claimant's upper extremity complaints were appropriate. This conclusion was not altered, even after Dr. Jewell learned of Meece's inappropriate back and coccyx adjustments.

Such circumstances do not support a conclusion that Safeway's payment of Dr. Meece's bill, as well as claimant's temporary disability benefits during the time in question, were incurred as a result of Meece's low back and coccyx treatments. To the contrary, the record establishes that Dr. Meece's bills pertained to claimant's compensable upper extremity condition and that claimant's compensable condition remained disabling (notwithstanding the low back and coccyx adjustments) during the time which Safeway seeks reimbursement.

Consequently, Safeway has failed to establish that the compensation for which it seeks reimbursement was incurred as a result of the alleged malpractice. Accordingly, we hold that Safeway is not entitled to a share of settlement proceeds stemming from claimant's malpractice action against Dr. Meece.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSE L. HERNANDEZ, Claimant
WCB Case No. 90-05284
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Steven R. Cotton (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Michael V. Johnson's order which set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

We affirm and adopt the Referee's order except for the portion entitled "Reasoning Underlying Specific Findings of Fact" and add the following supplementation.

We agree with the Referee that claimant successfully proved a claim for aggravation under former ORS 656.273(1). The medical evidence, primarily from Dr. Anderson, claimant's treating physician throughout the relevant time periods, proves that claimant suffered a temporary exacerbation of his symptoms rendering him less able to work. On January 3, 1990, Dr. Anderson took claimant off work, stating that he was "suffering from aggravation of old injuries." (Ex. 21A). Anderson subsequently reported that claimant "did suffer at least an exacerbation" but that, by March 9, 1990, "his injury-pain complaints [have] essentially stabilized." (Ex. 23A). That opinion was reiterated in a later report, where Anderson stated that claimant "had at least an interim worsening of his condition" but no "additional impairment." (Ex. 23E-1). Anderson released claimant for "trial work" on March 12, 1991. (Ex. 23D). Claimant returned to his former work planting and trimming trees. (Tr. 21, Ex. 24-2).

Anderson's opinion that claimant suffered a temporary exacerbation of symptoms in late 1989 and early 1990 is not contradicted by the remaining medical reports. Those reports support the proposition that claimant has suffered no permanent impairment as a result of his compensable injury. However, they do not address the issue of whether claimant's compensable condition worsened temporarily in late 1989 and January 1990. Because resolution of this question involves a comparison of claimant's condition before and during the alleged exacerbation, we defer to the opinion of claimant's treating physician.

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 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 and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 16, 1991 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the SAIF Corporation.

January 16, 1992 Cite as 44 Van Natta 79 (1992)

In the Matter of the Compensation of
WILLIS W. STAMM, Claimant
WCB Case No. 91-00132
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Podnar's order which assessed a penalty for an allegedly unreasonable denial of claimant's arm injury claim. On review, SAIF contends that its denial was not unreasonable. We reverse.

FINDINGS OF FACT

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

CONCLUSION OF LAW AND OPINION

A penalty is assessable under amended ORS 656.262(10) when a carrier "unreasonably delays or unreasonably refuses to pay compensation." The reasonableness of a carrier's denial must be gauged based upon the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). The standard for determining whether a denial is unreasonable is whether the carrier had a legitimate doubt as to its liability for the claim. Brown v. Argonaut Insurance Co., supra.

SAIF denied the claim on the basis that claimant's injury did not arise from his employment and that SAIF had been unable to obtain a statement from claimant as to the circumstances surrounding the incident. (Ex. 13). SAIF's denial was apparently based, in part, on the employer's statement on the "801" claim form that:

> "Worker had just been told not to do what he did. Worker was attempting to mount a tire, using a tire machine, on a mag wheel. Worker over inflated the tire and it exploded. Pieces of tire struck worker breaking arm and causing glasses to break." (Ex. 2). (Emphasis in original).

At hearing, in support of its assertion that claimant had been told not to continue to work on the tire in question, SAIF presented evidence that the employer had a policy against employees working on "mag wheels." The Referee rejected that evidence, finding a lack of a company policy against working on certain wheels. The Referee reasoned that claimant was not aware of such a policy and that there was admittedly no written policy to this effect. However, assuming that claimant was in fact unaware of the policy, such a conclusion does not negate a finding that such a policy existed. Moreover, given the fact that the employer here is a service station, we are unwilling to conclude as the Referee did that a policy against working on a certain type of wheel would be formally reduced to writing.

In sum, we accept SAIF's evidence that its insured had an oral policy against working on the type of wheel involved in claimant's injury. Further, SAIF's assertion in its denial that it was unable to obtain a statement from claimant concerning the circumstances of his injury is unrebutted. Therefore, despite its apparent efforts, SAIF had no knowledge of claimant's assertion that he was unaware of such a policy. Moreover, in light of existing case law, SAIF's belief that the claim would not be compensable if claimant consciously violated a known work policy is not unreasonable. See Agripac v. Zimmerman, 97 Or App 512 (1989). Under these circumstances, we conclude that SAIF had a legitimate doubt as to the compensability of claimant's claim.

ORDER

The Referee's order dated April 18, 1991 is reversed in part. That portion of the Referee's order that assessed a penalty pursuant to ORS 656.262(10), with one half of the penalty payable to claimant's counsel in lieu of an attorney fee, is reversed. The remainder to the Referee's order is affirmed.

In the Matter of the Compensation of
RODNEY E. ANGERBAUER, Claimant
WCB Case No. C1-02715
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Emmons, Kropp, et al., Claimant Attorneys

Reviewed by Board Members Neidig and Moller.

On December 17, 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.

By order dated December 31, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) on the basis that the agreement provided for processing matters outside of Chapter 656 and therefore was not appropriate for disposition under ORS 656.236 and the rules promulgated thereunder. The parties have requested reconsideration of our order by submitting a modified disposition agreement that has deleted the objectionable language.

The Rules of Practice and Procedure relating to requests for reconsideration of orders disapproving claim disposition agreements were amended effective September 2, 1991. WCB Admin. Order 5-1991 (August 21, 1991). OAR 438-09-035 provides that:

> "(1) A motion for reconsideration of final orders issued by the Board under ORS 656.236 and these rules shall be filed within 10 days of the date of mailing of the order.
>
> (2) The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration:
>
> (a) Is filed in accordance with section (1); and
>
> (b) States specifically the reasons(s) reconsideration is requested.
>
> (3) Reconsideration of a final order issued by the Board under ORS 656.236 and these rules shall be limited to the record before the Board at the time its final order was mailed and no additional information will be considered, unless the Board finds good cause for allowing the additional submission."

The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration is filed within ten days of the date of mailing of the order. OAR 438-09-035(2)(a) and (1).

Here, the disapproval order was mailed on December 31, 1991, and the insurer's request for reconsideration was filed on January 9, 1992, 9 days after the date of mailing of the order. Thus, the Board finds claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Consequently, we may consider the motion for reconsideration. OAR 438-09-035(2). Moreover, upon review of the addendum, we find good cause for allowing the additional submission. Accordingly, we will consider this information on reconsideration. See OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991).

In support of their motion for reconsideration, the parties have submitted a revised agreement which removed the language which concerned matters outside of Chapter 656.

Accordingly, we grant the motion for reconsideration. On reconsideration, we find that this agreement is now in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of this agreement is also approved.

IT IS SO ORDERED.

January 17, 1992 Cite as 44 Van Natta 82 (1992)

In the Matter of the Compensation of
GARY O. BROWN, Claimant
Own Motion No. 84-0266M
OWN MOTION ORDER OF ABATEMENT
Emmons, et al., Claimant Attorneys
SAIF Legal Department, Defense Attorney

Claimant requests reconsideration of our December 19, 1991 Own Motion Order Reviewing Carrier Closure that affirmed SAIF's August 22, 1991 Notice of Closure in the above-captioned case. Claimant submitted additional evidence to support of his contention he is not medically stationary.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within ten days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

January 17, 1992 Cite as 44 Van Natta 82 (1992)

In the Matter of the Compensation of
LINDA J. HASSLEN, Claimant
WCB Case No. 88-20402
ORDER ON REMAND
Welch, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Boise Cascade Corporation v. Hasslen, 108 Or App 605 (1991). The court has partially reversed our prior order, Linda J. Hasslen, 42 Van Natta 1558 (1990), which held that both of the self-insured employer's denials were improper prospective denials. The court has agreed that the portion of the employer's November 15, 1988 denial, which denied responsibility for "any disability as compensably related to this injury," was prospective. Thus, that portion of our prior order has been affirmed. However, the court has concluded that the remaining portion of the November 15, 1988 denial and all of the October 25, 1988 denial were valid. Consequently, the court has remanded with instructions to "consider whether the requested medical services are reasonable and necessary to treat claimant's compensable industrial injury."

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

To establish the compensability of her current low back condition, claimant must prove that her 1984 compensable low back injury is a material contributing cause of her low back disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). Considering the length of time which has elapsed since claimant's 1984 low back strain injury and in light of her extensive medical and psychological history, we conclude that the causation issue is a complex medical question. Thus, resolution of this issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

After a de novo review of the record, we conclude that claimant has failed to carry her burden to prove a causal relationship between her compensable injury and the medical treatment at issue here.

Claimant relies on the opinion of her treating physician, Dr. Nelson, a general practitioner, to argue that her medical treatment is related to her compensable injury. Dr. Nelson opined that claimant has "continued to have back problems and has been receiving pain medication all along." (Ex. 45-1). In a chart note, Dr. Nelson also makes the statement that claimant's back pain "seems to be the same old thing she has had for a long time." (Ex. 40-3).

Notwithstanding these references, Dr. Nelson also concurred with two letters from the insurer stating that claimant's current condition requiring treatment is unrelated to the accepted injury. Dr. Nelson later explained that he was referring to treatment for claimant's herpetic infection, headaches and an episode of diarrhea, nausea and vomiting.

We consider Nelson's statements to be insufficient to prove a causal connection between claimant's 1984 compensable injury and the medical services at issue. Even if we could construe Dr. Nelson's opinion as indicating that the compensable injury is a material contributing cause of her current back problems and resulting need for treatment, his opinion lacks explanation and analysis and is therefore not persuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). We find these omissions particularly noteworthy when considered in light of the contrary medical opinions and claimant's complex medical and psychological history.

Dr. Holland, psychiatrist, examined claimant for the purpose of determining whether a psychological condition existed which was causally related to claimant's occupational injury. (Ex. 48). Dr. Holland concluded that claimant's psychiatric problems preexisted the date of injury and bore no causal relationship to the injury. Dr. Holland subsequently added that he did not find a material causal relationship between claimant's compensable injury and her current pain disorder. He opined that, but for claimant's preexisting psychological problems, obesity and the psychosocial stressors in her personal life, claimant would not be currently manifesting a myofascial pain syndrome. (Ex. 50). Dr. Holland identified these significant psychosocial stressors as the uninsured loss of claimant's home to fire, her brother-in-law's death from cancer, her treatment for alcoholism, the molestation of her daughter by a youth counselor, and the death of her sister-in-law in an automobile accident. (Ex. 48-8, 9). We find Dr. Holland's opinion to be both thorough and well reasoned. Consequently, we find it persuasive. Somers v. SAIF, 77 Or App 259 (1986).

Dr. Mahoney, internist, treated claimant in 1984 and 1985. Although he had not examined claimant since July 1985, Mahoney opined that there was no material causal relationship between the compensable injury and claimant's current low back condition. Dr. Mahoney explained that when he saw claimant for her low back condition she was having severe situational depression as a result of a very difficult home situation. He opined that these situational problems were the primary causal factor in claimant's low back pain. (Ex. 51).

Dr. Affley, an occupational medicine consultant, performed a file review and testified at hearing. Dr. Affley concluded that in the normal course of events, claimant's 1984 strain should have resolved in a period of several days or weeks. Dr. Affley listed claimant's herpes zoster infection, obesity and social stressors as other potential causes of claimant's continued back pain. Consequently, Dr. Affley opined that claimant's symptoms requiring treatment were largely related to life stresses and not to her 1984 compensable injury.

Considering the contrary medical opinions, especially the persuasive opinion of Dr. Holland, we conclude that Dr. Nelson's conclusory statements concerning a causal relationship between claimant's 1984 compensable injury and her current low back condition are insufficient to establish that claimant's compensable injury is a material cause of her current need for medical services. Consequently, we hold that the requested medical services denied by the employer's denials are not compensable.

In light of this decision, we need not address claimant's entitlement to an attorney fee for finally prevailing against the employer's denials after remand. Inasmuch as claimant has not prevailed against the denials after remand, the issue is moot.

Accordingly on reconsideration, we reverse that portion of the Referee's order dated March 31, 1989 which set aside the employer's October 25, 1988 denial. The denial is reinstated and upheld. In addition, we reverse the Referee's order to the extent that the employer's November 15, 1988 denial was set aside in its entirety. The denial is reinstated and upheld to the extent that it denied claimant's "current treatment needs." Consistent with the court's decision, that portion of the denial which denied responsibility for "any disability as compensably related to this injury" remains set aside as prospective.

As a result of this decision, the Referee's attorney fee award for prevailing at hearing against the denials and our prior attorney fee award for services on review shall be modified. 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 at hearing concerning the prospective portion of the employer's November 15, 1988 denial is $750 and a reasonable fee for services on review concerning the successful defense of that issue is $300. Both fees shall be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDGAR A. POWELL, Claimant
WCB Case No. 90-21034
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Quillinan's order that set aside its denial of claimant's cervical condition at C4-5 on the basis of res judicata. Claimant cross-requests review of that portion of the Referee's order that upheld the SAIF Corporation's denial of his medical services claim for L1-2 surgery. On review, the issues are res judicata and compensability.

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

We agree that SAIF is precluded from denying compensability of claimant's C4-5 cervical condition on the basis of issue preclusion. The issue of whether claimant's cervical condition, at all levels, is compensably related to the industrial injury was litigated in the earlier Referee's order in which he found that the industrial injury had worsened claimant's cervical spondylosis. The earlier Referee's order has become final as a matter of law. Therefore, SAIF is precluded from denying the compensability of claimant's cervical condition. See Drews v. EBI Companies, 310 Or 134 (1990); North Clackamas School District v. White, 305 Or 48, on recon 305 Or 468 (1988).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the C4-5 cervical condition is $1,000, to be paid by the SAIF Corporation . 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 3, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
PENNY L. WILSON, Claimant
WCB Case No. 90-14232
ORDER ON REVIEW
Douglas S. Hess, Claimant Attorney
Miller, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of Referee Tenenbaum's order which set aside its denial of claimant's occupational disease claim for a psychiatric condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last sentence of the fifth paragraph on page 2, the first full sentence appearing on page 3, the last two sentences of the third paragraph on page 3, the fourth paragraph on page 4, and the first two paragraphs on page 5.

CONCLUSIONS OF LAW AND OPINION

Under ORS 656.802(1)(b), "occupational disease" includes any mental disorder which requires medical services or results in physical or mental disability or death. The worker must prove that employment conditions were the major contributing cause of the disease and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must not be generally inherent in every working situation; there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

The employer asserts that claimant failed to prove that employment conditions were the major contributing cause of her mental condition and that there was not clear and convincing evidence that her mental disorder arose out of and in the course of employment. Specifically, the employer contends that claimant began experiencing depression in January 1990, at which time she was in Special Handling and not experiencing job stress, and that she experienced off-the-job stressors, including a longer drive commute. We agree.

Claimant attributes the stress she experienced to her work in collections and the introduction of the autodialer system. However, the record establishes that claimant, in fact, began experiencing depression in January 1990, before claimant was asked to transfer to the collections department. (Ex. 7A-1). At that time, because claimant's depression appeared to be cyclic, a physiological explanation was considered. Moreover, on March 12, 1990, claimant was referred for an "urgent" mental health consultation by P. Fleury, a nurse practitioner. (Ex. 7). Claimant subsequently saw Susan Hook, M.S., who reported that claimant experienced a "major depressive episode" on approximately March 9, 1990. (Ex. 7A-1). However, it was not until April 16, 1990, that the autodialer system went on line. (Tr. at 89).

Moreover, we agree that the medical evidence shows that claimant's mental condition was, in significant part, caused by an increased driving commute from a local 10-minute drive on Portland's eastside to a 30-minute cross-town commute which claimant found extremely stressful. From the outset, nurse practitioner Fleury recounted two factors which claimant attributed to causing her distress: "I have been getting very frightened about driving to work and the pressure at work is really upsetting me * * *." Similarly, Susan Hook, who saw claimant on a weekly basis, identified "recent stresses" to include a longer drive commute, as well as a turnover in her job's management team and the introduction of the autodialer. (Ex 7A-1). Further, Dr. Turco, who conducted an independent psychiatric examination of claimant, attributed claimant's adjustment disorder to three factors, including the commute, the autodialer, and "the general 'burnout' feeling with collections." (Ex 22-8). Moreover, in his report, Turco described in considerable detail the stress claimant experienced as a result of her new, extended commute. The history recounted by Turco included the fact that claimant had previously turned down a job offer with the employer because it required a downtown commute; that, on arrival at work in the morning and returning home at night, claimant needed to remain in her car for 15 minutes in order to stop

shaking and to recover from her commute; and that claimant had changed her appointment with Turco so that a friend could drive her to the downtown Portland appointment rather than driving herself. Finally, Turco noted that claimant would turn down any subsequent job offer with the employer at its Beaverton office because she views the driving as being much too stressful.

We are, therefore, persuaded that the commute was a significant factor in causing claimant's mental condition. We further conclude that claimant's commute is not a cognizable work-related stressor under ORS 656.802. See Gwin v. Liberty Northwest Ins. Co., 105 Or App 171 (1991)(injuries occurring while traveling to and from work are not generally compensable). Although both Hook and Turco report that there were work-related causes for claimant's mental condition --namely, the autodialer and collections work-- neither of them explains the relative contribution of each of the factors, including the commute. In this regard, it is claimant's burden to prove by clear and convincing evidence that work-related factors were the major contributing cause of her mental disorder. Katherine E. Thrash, 43 Van Natta 846 (1991). In the absence of an explanation of the weight to be given the various factors, and in light of the apparent significance of the commute as a contributing factor, the record is not "free from confusion, fully intelligible and distinct" to the effect that cognizable work conditions were the major contributing cause of claimant's condition. Riley Hill General Contractors, Inc. v. Tandy Corp., 303 Or 390 (1987). Therefore, because the medical evidence fails to demonstrate that employment conditions alone were the major contributing cause of claimant's mental disorder, we are unable to conclude that her claim is compensable.

Because we conclude that claimant failed to prove that employment conditions were the major contributing cause of her mental condition, we do not address the employer's remaining assertions that claimant failed to prove that employment conditions causing her mental disorder existed in a real and objective sense and that the alleged employment conditions are not generally inherent in all working situations.

ORDER

The Referee's order dated February 27, 1991 is reversed. The employer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

January 17, 1992 Cite as 44 Van Natta 87 (1992)

In the Matter of the Compensation of
STEVEN E. WILSON, Claimant
WCB Case No. C1-02707
ORDER DENYING RECONSIDERATION
Malagon, et al., Claimant Attorneys

Reviewed by Board Members Neidig and Moller.

On December 16, 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.

By order dated December 24, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) on the basis that the agreement provided for an attorney fee in excess of the limit set by OAR 438-15-052, without an indication

of extraordinary circumstances. Claimant's counsel has requested reconsideration of our order contending that claimant's attorney fee is not excessive.

The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration is filed within ten days of the date of mailing of the order. OAR 438-09-035(2)(a) and (1).

Here, the disapproval order was mailed on December 24, 1991, and claimant's request for reconsideration was filed on January 6, 1991, thirteen days after the date of mailing of the order. Thus, the Board finds that claimant's request for reconsideration was not timely filed in accordance with OAR 438-09-035(1).

Consequently, we decline to consider the motion for reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL H. McDONALD, Claimant
WCB Case Nos. 90-19825, 90-19343, 90-08651, 90-19824 & 90-08652
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney
VavRosky, et al., Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee McCullough's order which: (1) declined to award an assessed attorney fee for the SAIF Corporation's rescission of the compensability portion of its March 22, 1990 denial; and (2) declined to award an assessed attorney fee for setting aside Liberty Northwest's October 5, 1990 responsibility denial. On review, the issue is attorney fees.

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

Concerning SAIF's compensability rescission, we agree with the Referee's conclusion that the record fails to establish that services rendered by claimant's counsel were instrumental in obtaining SAIF's rescission. Or Laws 1991, SB 540. We accordingly affirm the Referee on this basis.

ORDER

The Referee's order dated March 15, 1991 is affirmed.

In the Matter of the Compensation of
RAYMOND THORNSBERRY, Claimant
Own Motion No. 66-0298M
OWN MOTION ORDER
Roll, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant submitted a claim for medical services and temporary total disability benefits for an alleged worsening of his October 1, 1953 industrial injury, in which he experienced a crushed pelvis with bilateral sacroiliac dislocation, a lacerated urinary bladder, multiple abrasions, and paralysis of the left lower extremity. On March 7, 1990 claimant had a total right hip arthroplasty. SAIF has failed to provide a recommendation regarding this claim. See OAR 438-12-030.

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). In 1986, claimant developed increasing pain in his right leg and hip. (Dr. Whitney's letter of May 14, 1986). Dr. Whitney requested a right total hip replacement and knee surgery. (Letter of June 30, 1986). By a February 19, 1987 Own Motion Order, we found no relationship between claimant's right hip and leg problems and his 1953 injury and denied claimant's request for medical services and related temporary disability compensation. By a November 17, 1989 letter, SAIF denied an October 18, 1989 request for total right hip arthroplasty on the basis that this was the same surgery for the same body part that was denied in our prior order.

Claimant proceeded with the surgery on March 7, 1990, which is the subject of this request. We are precluded from relitigating claims and issues previously adjudicated. See Drews v. EBI Companies, 310 Or 134 (1990); Fred Lotfi, 43 Van Natta 430 1991. Here, because the compensability of claimant's right leg and hip condition was found to be unrelated to claimant's 1953 industrial injury, and because the current condition for which claimant requests benefits is the same condition for which he requested benefits in 1987, we deny the reopening of claimant's claim.

IT IS SO ORDERED.

January 21, 1992 Cite as 44 Van Natta 90 (1992)

In the Matter of the Compensation of
DIANE T. DAWES, Claimant
WCB Case No. 90-01550
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Kinsley's order that: (1) found that her claim had not been prematurely closed; (2) increased her scheduled permanent disability award for her left forearm condition from 5 percent (7.5 degrees), as awarded by Determination Order, to 10 percent (15 degrees); and (3) increased her scheduled permanent disability award for her right forearm condition from 5 percent (7.5 degrees), as awarded by Determination Order, to 10 percent (15 degrees). On review, the issues are premature closure and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Premature closure

The Referee concluded that claimant had not established that her claim was prematurely closed. We agree with the Referee, however, we base our conclusion upon the following analysis.

It is claimant's burden to establish that she was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981). The resolution of the medically stationary date is primarily a medical question which must be resolved based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985).

Claimant contends that she was not medically stationary on November 13, 1989, the date of closure. Claimant argues that Dr. Knox, her treating physician as of October 24, 1989, has reported that claimant was not medically stationary and has not been medically stationary since he began seeing her on that date. Claimant contends that the medications and physical therapy prescribed by Dr. Knox also indicate that there was a reasonable expectation of improvement. Finally, claimant asserts that statements made by Dr. Karasek and Dr. Jewell

that claimant's symptoms would gradually resolve supports her contention that other physicians had a reasonable expectation that her condition would improve.

We do not agree that claimant was not medically stationary on the date of closure. Since her claim was reopened, claimant's condition had been found to be medically stationary by Drs. Coletti, Chester and Jewell. In May 1989, Dr. Chester reported claimant's "psychosocial contribution to impairment" and her symptom amplification during examination. Dr. Chester recommended claim closure. In July 1989, Dr. Jewell, claimant's treating physician, reported that he agreed with Dr. Chester's report and concluded that it would be to claimant's benefit to close her claim. Finally, on October 12, 1989, Dr. Cohen examined claimant and reported that claimant did not need further treatment. Dr. Cohen also recommended closure of the claim.

We are not persuaded by the report of Dr. Knox, who became claimant's treating physician on October 24, 1989. In November 1990, Dr. Knox reported that claimant was not medically stationary and she had never been medically stationary since he began treating her in 1989. We agree with the Referee's reasoning that Dr. Knox's opinion is not persuasive as he was primarily treating her for conditions other than her accepted bilateral arm condition. Moreover, Dr. Knox has not addressed the opinions of the other physicians, including that of Dr. Jewell, claimant's previous treating physician, who have all reported that claimant was medically stationary and have recommended claim closure.

Finally, although claimant concedes that Dr. Knox has not been able to successfully treat her bilateral arm condition, claimant contends that the issue is whether or not there was a reasonable expectation of improvement. We agree with the Referee that, throughout Dr. Knox's treatment, claimant's condition has remained unchanged. Furthermore, we conclude that the persuasive medical evidence establishes that, as of the date of claim closure, there was no reasonable expectation that claimant's condition would improve. Accordingly, we affirm the Referee on the issue of premature closure.

Extent of scheduled disability

We affirm the Referee on the issue of extent of scheduled permanent disability.

ORDER

The Referee's order dated February 28, 1991 is affirmed.

January 21, 1992 Cite as 44 Van Natta 91 (1992)

In the Matter of the Compensation of
CHRISTINE A. DEGRAUW, Claimant
WCB Case No. 90-18720
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Darryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Tenenbaum's order which dismissed claimant's hearing request, finding that the Board does not have jurisdiction to evaluate whether claimant's claim is disabling until the Evaluation Division has classified it as nondisabling and claimant has appealed thereon. The issue on review is jurisdiction. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSION OF LAW AND OPINION

The Referee concluded that where a claim is not classified as nondisabling until over a year after it has been filed and over a year after the date of injury or occupational disease, sections 48(1) and (2) of Oregon Laws (Special Session, chapter 2, which state that the worker has one year from the date of injury to request reclassification of a nondisabling claim to disabling, do not apply. We agree, but offer the following analysis.

Section 48(3) provides, in pertinent part:

"A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

" * * * *

"(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon . . . ."

Section 48(3)(c) does not restrict claimant to a time limit in which to contend a nondisabling claim is disabling. Accordingly, claimant may make a request of the Evaluation Section for a determination of disabling status of her initial claim. We conclude that we do not have jurisdiction until claimant first exhausts the administrative remedy as provided for in Section 48(3)(c).

ORDER

The Referee's order dated February 20, 1991 is affirmed.

In the Matter of the Compensation of
RALPH B. DePAUL, Claimant
WCB Case No. 86-14571
CORRECTED ORDER ON REVIEW
Daryll E. Klein, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee Daughtry's order which dismissed claimant's hearing request. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

Claimant was compensably injured in 1979. SAIF denied an aggravation of the 1979 injury on January 24, 1986, On February 26, 1986, claimant, pro se, requested a hearing on SAIF's aggravation denial. On May 23, 1986, claimant, then represented by counsel, filed a supplemental request for hearing to appeal a June 3, 1985 Determination Order. On July 9, 1986, claimant filed a second supplemental request for hearing, raising penalties and attorney fees for unreasonable denial. On July 17, 1986, claimant's counsel asked that the case be placed in inactive status.

On July 21, 1986, Referee Podnar issued an Order of Dismissal stating that the claim was dismissed "preserving to claimant his right to request a hearing on any issued (sic) raised or raisable." This Order of Dismissal was an appealable order and contained a statement of appeal rights. This order was never appealed. Thereafter, on August 5, 1986, claimant's attorney wrote Referee Podnar asking him to reconsider his Order of Dismissal and place the case in inactive status. Referee Podnar denied claimant's request stating that he did not wish to prejudice claimant and reiterating his belief that the issues raised by claimant's request were preserved.

On October 22, 1986, claimant again requested a hearing on the same issues specified in the earlier request and amended requests for hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's request for hearing was untimely, and therefore dismissed the request for hearing. SAIF contends that the Referee was correct. It argues that although the earlier referee's 1986 Order of Dismissal stated that it preserved claimant's right to a hearing on any issues raised or raisable, claimant was still required to file a new request for hearing within the time limits for appealing the Determination Order and the aggravation denial. We agree.

In Claudia I. Hamilton, 42 Van Natta 600 (1990), we held that the "reservation" of issues raised by a request for hearing amounts to a dismissal of those issues without prejudice. Those issues can then be reraised at any time within the time limits set out by ORS 656.319. In Hamilton, no request for hearing was made before the Determination Order became final as a matter of law. Therefore, we held that the appeal of the Determination Order was untimely. See also David L. Mallette, 38 Van Natta 843 (1986).

Similarly, in the present case, although the earlier referee intended to preserve the issue of the extent of claimant's permanent disability, claimant did not timely appeal the June 3, 1985 Determination Order.

Accordingly, we affirm the Referee's order dismissing this matter for lack of jurisdiction. Glen D. Roles, 42 Van Natta 68 (1990).

ORDER

The Referee's order dated April 9, 1991 is affirmed.

January 22, 1992 Cite as 44 Van Natta 93 (1992)

In the Matter of the Compensation of
HARLIE B. GILLIAM, Claimant
WCB Case No. 90-11937
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Peterson's order which: (1) found claimant had failed to establish any permanent disability resulting from his industrial injury; (2) found that claimant was not entitled to further temporary total disability; (3) declined to assess a penalty against the insurer for failing to pay temporary disability ordered by a Determination Order; and (4)

declined to assess a penalty against the insurer for unreasonable resistance to payment of compensation for initially classifying claimant's claim as nondisabling. On review, the issues are extent of permanent disability, entitlement to temporary total disability compensation and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

We adopt the conclusions and reasoning concerning the issue of scheduled permanent disability as set forth in the Referee's order.

Temporary Disability

On May 7, 1990, the Governor signed into law Senate Bill 1197, an extensive revision of the workers' compensation statutes. See Or Laws 1990 (Special Session), ch. 2. Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, we analyze this matter under amended ORS 656.268.

Claimant argues entitlement to further temporary total disability compensation. The Referee found that claimant refused to take a drug screen required by a collective bargaining agreement, and, under the terms of the collective bargaining agreement, claimant voluntarily quit his job by refusing to take the test. The Referee reasoned that the employer was not required to make a written offer of work in order to terminate temporary total disability, since claimant had voluntarily quit his job. Therefore, the Referee concluded that claimant was not entitled to further temporary total disability compensation. We do not agree.

Amended ORS 656.268(3) explicitly sets out the conditions for unilateral termination of temporary total disability compensation. It provides:

> "(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:
>
> "(a) The worker returns to regular or modified employment;
>
> "(b) The attending physician gives the worker a written release to return to regular employment; or
>
> "(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

When a worker is released to modified work by his physician, and has not yet returned to modified work, the employer must give the worker a written offer of employment and the worker must fail to begin such employment, before the employer may unilaterally terminate temporary total disability compensation. ORS 656.268(3)(c). That did not occur here. Although claimant's physician gave him a written release to return to modified employment, this employment was never offered to claimant in writing as required before temporary total disability may be terminated.

In Soledad Flores, 43 Van Natta 2504 (1991), we held that ORS 656.268, as amended, was intended to make it easier for a carrier to unilaterally terminate temporary total disability in order to limit the need to offset overpayments of temporary disability which might never be recovered. In Flores, we distinguished between substantive entitlement to temporary total disability and procedural entitlement to temporary disability.

In this case, the insurer did not even comply with the lesser procedural requirements of the amended statute when it terminated temporary total disability. Although claimant may not ultimately be substantively entitled to temporary total disability, procedurally the insurer could not terminate temporary total disability without meeting the criteria set forth in the statute. Accordingly, we conclude that the insurer improperly terminated temporary total disability.

Penalties and Attorney Fees

We adopt the conclusions and reasoning of the Referee on the issue of penalties for improper classification of claimant's claim as nondisabling.

Claimant also contends he is entitled to a penalty for improper termination of temporary total disability. At the time the insurer unilaterally terminated claimant's temporary total disability, it was required to conform its conduct to former ORS 656.268. We have previously held that there is nothing anomalous in a decision by the legislature to apply amended ORS 656.268(3) retroactively to all existing claims, thereby requiring the claimant's entitlement to temporary total disability benefits to be determined by the amended statute. See Rocky L. Coble, 43 Van Natta 1907 (1991).

Here, the insurer's conduct was unreasonable under both the 1990 amendments and the law prior to July 1, 1990. Under the law and the rules which applied at the time the insurer unilaterally terminated claimant's temporary total disability, the insurer's actions were unreasonable. The insurer did not comply with former OAR 436-60-030(5)(c) before terminating temporary total disability. Under the law in effect prior to the 1990 amendments, an insurer could not procedurally terminate temporary total disability until the worker was either released to regular work, or had returned to regular work and was medically stationary. See former ORS 656.268; Fazzolari v. United Beer Distributors, 91 Or App 592, on recon 93 Or App 103, rev den 309 Or 326 (1988).

Here, claimant was not released to regular work, did not return to regular work and was not medically stationary. Thus, under both the law in effect at the time of the insurer's conduct, and the 1990 amendments, the insurer's conduct in terminating temporary total disability was unreasonable. Claimant is, therefore, entitled to a penalty of 25 percent of the compensation then due for its unreasonable refusal to pay compensation. ORS 656.262(10)(a). Claimant's attorney is entitled to one-half of this additional amount in lieu of an attorney fee. Id.

ORDER

The Referee's order dated April 10, 1991 is affirmed in part and reversed in part. That portion of the Referee's order which found that claimant was not entitled to further temporary total disability compensation is reversed. Claimant is awarded temporary total disability from August 18, 1989 through October 3, 1989. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. Claimant is awarded a penalty equal to 25 percent of all temporary disability compensation owing at the time of hearing as a result of this order, payable by the insurer. Claimant's attorney shall receive one-half of the penalty, in lieu of an attorney fee. The remainder of the order is affirmed.

In the Matter of the Compensation of
JAMES P. STEPHAN, Claimant
WCB Case No. 90-18575
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of that portion of Referee Tenenbaum's order that set aside its denial of claimant's claim for a low back injury. On review, the issue is compensability.

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

The Referee concluded that the issue is whether claimant's work activities on July 20, 1990 were a material contributing cause of disability or need for treatment for the lumbar strain. We agree. Claimant established that he suffered a relatively minor strain which did not worsen or in any other way, effect his preexisting spondylolisthesis and spondylolysis. Therefore, the work injury did not "combine" with the preexisting conditions within the meaning of ORS 656.005(7)(a)(B). Consequently, the major contributing course standard of that provision did not apply to claimant's claim. On the other hand, the employer is not responsible for the preexisting conditions. See Bahman M. Nazari, 43 Van Natta 2368 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. 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 attorney's services on review is $500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 22, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $500, payable by the self-insured employer.

In the Matter of the Compensation of
WILLIAM A. STEVENSON, Claimant
WCB Case No. 90-22185
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Tom Ewing, Assistant Attorney General

Reviewed by Board Members Westerband and Gunn.

The Department of Justice, Inmate Injury Fund (Fund), requests review of Referee Otto's order which: (1) found that claimant had timely filed a written claim with the Department of Justice within 90 days of his right knee injury; and (2) set aside the Fund's denial of claimant's right knee injury claim. Contending that claimant did not timely file a written claim with the Department, the Fund seeks reinstatement of its denial. We agree and reverse.

FINDINGS OF FACT

We adopt the Referee's "Stipulated Facts" and "Findings of Fact." We do not adopt the Referee's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that infirmary notes from a physician at the Oregon State Correctional Institute (OSCI) constituted a written claim to the Department of Justice which were filed within 90 days of claimant's right knee injury. Consequently, the Referee held that claimant's injury claim was not barred under ORS 655.520(3). We disagree.

Rights to benefits under ORS 655.505 to 655.550 shall be barred unless a written claim is filed with the Department of Justice within 90 days after the injury, or unless the Department waives the time limit on the ground that, "for good and sufficient reason, the claim could not be filed on time." ORS 655.520(3); Dept. of Justice v. Bryant, 101 Or App 226, 229 (1990). The exceptions to timely filing of a workers' compensation claim under ORS 656.265(4)(a) are not applicable to an inmate injury claim filed under ORS chapter 655. Dept. of Justice v. Bryant, supra. Furthermore, subsequent to the Referee's order, we held that the submission of written letters to the Corrections Division does not constitute filing of a written claim with the Department of Justice under ORS 655.520(1) and (3). Kenneth G. Riley, 43 Van Natta 1380, 1381 (1991).

Here, claimant suffered his right knee injury on December 13, 1988. He sought medical treatment from the OSCI infirmary for his injury shortly thereafter. Such treatment is documented in a series of chart notes, progress reports, and an October 1989 MRI report. Nevertheless, these materials were not submitted to the Department of Justice until sometime after claimant filed his written claim for benefits with the Department under the Inmate Injury Fund. Inasmuch as that claim was not filed until June 21, 1990, more than 90 days after claimant's December 13, 1988 injury, and the Department has not waived the 90-day statutory time limit, the claim is barred as untimely. See ORS 655.520(3); Dept. of Justice v. Bryant, supra; Kenneth G. Riley, supra.

ORDER

The Referee's order dated March 11, 1991 is reversed. The Department of Justice's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

January 22, 1992 Cite as 44 Van Natta 97 (1992)

In the Matter of the Compensation of
BOB E. TAYLOR, Claimant
WCB Case No. C1-02680
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Reynolds & Bendixsen, Claimant Attorneys
Liberty Northwest Insurance Corporation, Insurance Carrier

Reviewed by Board Members Neidig and Moller.

On December 9, 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 a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

On December 17, 1991, the Board requested an addendum providing whether claimant has been able to return to the work force. On January 13, 1992, the Board received an addendum signed by all the parties providing this information.

A proposed claim disposition agreement must be set aside if we find that it is the result of an intentional misrepresentation of material fact. ORS 656.236(1)(b). Misrepresentation is an intentional, false statement of a substantive fact, or any conduct which leads to a belief of a substantive fact material to a proper understanding of the matter in hand, made with the intent to deceive or mislead. Louis R. Anaya, 42 Van Natta 1843 (1990).

Here, the insurer alleges that, when the parties entered into this agreement, it was unaware that claimant was released to his regular occupation as a chip truck driver. Further, the insurer alleges that the Claims Disposition Agreement was intended to compensate claimant for vocational services due to the fact that he could not return to his regular occupation and that claimant had advised the insurer that he would be using the funds to retrain himself for a new occupation. The insurer further asserts that recent contact with claimant's current employer found that claimant had returned to work with them in the occupation of a chip truck driver and that he continues to be their employee.

The insurer submits an August 29, 1991 letter with attached chartnotes from Dr. Berselli which report that: (1) he last saw claimant on August 5, 1991; (2) claimant is medically stationary; (3) claimant indicated that he would like to obtain a new job as a Corrections Officer; and (4) Dr. Berselli opined that that was a feasible job from a physical standpoint.

Additionally, the insurer submits a January 7, 1992 letter from Dr. Berselli stating that claimant " . . . is able to return to his occupation of a truck driver." The insurer also submits a permanent residual physical capacity evaluation dated November 7, 1991. In this evaluation, Dr. Berselli noted: "Last seen on 9/6/91 -- Status quo. He missed scheduled appointment on 10/7/91." He further reported that claimant was released for his customary and usual work.

The aforementioned records do not establish that the Claims Disposition Agreement was intended to compensate claimant for vocational services due to the fact that he could not return to his regular occupation and that claimant had advised the insurer that he would be using the funds to retrain himself for a new occupation. To the contrary, by his physical capacity report dated November 7, 1991, received by the insurer the next day, Dr. Berselli indicated that, despite certain restrictions, claimant was released for regular work. Further, on December 20, 1991, the insurer signed an addendum acknowledging that claimant had returned to the workforce.

Accordingly, we do not find that claimant made representations that were false and with the intent to deceive or mislead.

This agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of this agreement is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
DELORAS M. HUTCHENS, Claimant
WCB Case No. 90-11309
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Thye's order which: (1) held that claimant had not established good cause for failing to timely file a request for hearing on the self-insured employer's denial; and (2) upheld the self-insured employer's denial of her right arm condition and degenerative disease. In addition, claimant contends that the Referee erred in not admitting additional medical reports into evidence. We treat claimant's contention that these reports should have been admitted as a motion to remand for additional evidence. In its brief, the employer contends that claimant did not timely request Board review of the Referee's order. On review, the issues are timeliness of the requests for hearing and Board review and remand.

We affirm and adopt the Referee's order with the following comment concerning the timeliness and remand issues.

On April 10, 1991, claimant moved that the Referee abate and reconsider his order failing to find good cause for an untimely hearing request. In her motion, claimant asked the Referee to reopen the record and admit additional documents not admitted at hearing. On April 12, 1991, the Referee issued an "Order of Abatement and Denial of Motion to Reconsider." In his order, the Referee expressly abated and republished his original order in its entirety.

In its brief, the employer contends that the Referee's order denying reconsideration did not toll the 30 day period for appealing the original Opinion and Order. Therefore, the employer argues that claimant's request for review was filed more than 30 days after the Referee's March 13, 1991 Opinion and Order. We disagree.

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

Inasmuch as the Referee specifically abated his March 13, 1991 order when he issued his April 12, 1991 order, we conclude that claimant had 30 days from the issuance of the April 12, 1991 order to seek review. Compare Floarea Perua, 39 Van Natta 454 (1987) (Where "Order Denying Reconsideration" attempted to grant additional 30 days to appeal, but order neither modified, withdrew, stayed, nor republished prior order, appeal filed more than 30 days after initial order was untimely).

In light of the fact that we have affirmed the Referee's finding that claimant failed to establish good cause for failure to timely request a hearing, we do not address claimant's contention that the Referee erred in not admitting the post-hearing report of Dr. Smith or readmitting Dr. Peto's July 30, 1990 letter, which claimant withdrew at hearing. On the question of whether claimant established good cause for the untimely request for hearing, see Deanna L. Southerland, 42 Van Natta 608 (1990).

ORDER

The Referee's order dated March 13, 1991, as reconsidered April 12, 1991, is affirmed.

In the Matter of the Compensation of
RICHARD M. KUEHMICHEL, Claimant
Own Motion No. 91-0718M
OWN MOTION ORDER
Welch, et al., Claimant Attorney
Cigna Insurance Companies, Insurance Carrier

The insurer submitted a claim for an alleged worsening of claimant's October 30, 1973 right knee injury. Claimant's aggravation rights expired on April 6, 1984. The insurer has accepted the compensability of a recommended total right knee replacement surgery. However, it opposes the reopening of his claim for payment of temporary disability compensation, contending that claimant has removed himself from the work force.

We may exercise our own motion authority to reopen claimant's claim for additional temporary disability compensation if he has sustained a worsening of his compensable injury requiring either inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS 656.278(1)(a). We conclude that claimant has sustained such a worsening.

However, in order to qualify for the payment of temporary disability compensation, claimant must have been in the work force at the time of the worsening. In order to prevail, claimant must prove that he is willing to work and that either: (1) he is making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work would be futile due to the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). The insurer contends that claimant had withdrawn from the work force. Claimant states that his retirement was forced by the disabling effect of his compensable injury and that he remains willing and anxious to return to "the work force." Dr. Rusch, claimant's attending orthopedist, opined that claimant could have returned to modified work after his earlier left knee condition became medically stationary. He also reported that claimant had retired and did not anticipate a return to work. Claimant has provided no evidence that, prior to the current worsening of his right knee, he was unable to work due to the compensable injury, or that reasonable efforts to seek work would have been futile. The burden of proof lies with claimant. Accordingly, we conclude that claimant has withdrawn from the work force. Therefore, we deny his request for temporary disability compensation. See id.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD B. OLSON, Claimant
WCB Case Nos. 90-01934 & 89-23026
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Kevin L. Mannix, Defense Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Holtan's order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for a low back condition; and

(2) upheld Liberty Northwest Insurance Corporation's denial of his occupational disease claim for the same condition. On review, the issues are compensability and responsibility.

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

Claimant argues that retroactive application of Oregon Laws 1990 (Special Session), chapter 2, would violate his constitutional due process rights. However, he does not specify the due process rights that would be violated by retroactive application of the 1990 amendments. Inasmuch as the constitutional argument is not adequately developed for our review, we decline to address the issue. See Hall v. Northwest Outward Bound School, 280 Or 655, 661-62(1977); State ex rel Borisoff v. Workers' Compensation Board, 104 Or App 603, 607(1990).

ORDER

The Referee's order dated December 7, 1990, is affirmed.

January 23, 1992 Cite as 44 Van Natta 101 (1992)

In the Matter of the Compensation of
ERNEST C. RICHTER, Claimant
WCB Case Nos. 88-04556, 86-13711 & 85-12160
SECOND ORDER ON REMAND
Emmons, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Claimant requests reconsideration of our January 10, 1992 Order on Remand that awarded claimant's counsel an $800 carrier-paid attorney fee under ORS 656.386(1) when Argonaut Insurance rescinded its compensability denial of claimant's chiropractic treatment prior to hearing. Relying on his counsel's affidavit which was presented at the time of hearing and the fact that it has taken "three separate appeals to obtain the desired result," claimant asks that we increase the attorney fee award.

To begin, the issue before us on remand was the amount of a reasonable attorney fee for claimant's counsel's services in prompting the rescission of Argonaut's chiropractic denial without a hearing. Therefore, any of claimant's counsel's efforts devoted to reversing the Referee's order and our prior decision that claimant's attorney fee should be paid from compensation (although meritorious and ultimately successful), are irrelevant to a determination of a reasonable attorney fee for claimant's counsel's pre-hearing services. Moreover, because attorney fees do not constitute compensation, claimant would not be entitled to an attorney fee award for services rendered before the Board and court for "finally prevailing" on this issue. See ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 1314 (1991).

Claimant also objects to our award, contending that we found that he had "impliedly agreed" to the Referee's out-of-compensation attorney fee award. Referring to his affidavit, claimant asserts that he clearly expressed his disagreement with the amount of the Referee's award.

Claimant misinterprets our decision. Our order merely noted that, on review, claimant contested the Referee's and our prior holdings that the attorney fee should be paid from his compensation and that he did not expressly challenge the amount of his attorney fee award. Such a reference was not intended to

suggest a concession by claimant that the Referee's $800 attorney fee award was reasonable. Rather, the reference was inserted to describe claimant's appellate arguments.

Furthermore, as clearly stated in our decision, we considered all of the factors set forth in OAR 438-15-010(4) in reaching our determination regarding the amount of a reasonable attorney fee. After conducting that analysis (which included consideration of claimant's attorney's affidavit of services rendered), we found that a reasonable attorney fee concerning the rescission of Argonaut's chiropractic compensability denial prior to hearing is $800, to be paid by Argonaut. After reconsidering this matter in light of claimant's motion, we adhere to our prior reasoning and conclusion. We further note that benefits secured in the form of medical services are generally considered to be rather modest. Dwight E. Fillmore, 40 Van Natta 794 (1988), aff'd Weyerhaeuser Company v. Fillmore, 98 Or App 567 (1989).

Accordingly, we withdraw our January 10, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our January 10, 1992 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS R. SAUTER, Claimant
WCB Case Nos. 90-15605 & 90-12606
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Fire & Casualty Insurance Company of Connecticut (F&C) requests review of Referee Davis' order that: (1) set aside its denial of claimant's "new injury" claim for his cervical condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Facts" as our own as supplemented.

Dr. Hacker examined claimant on March 20, 1990 and noted decreased cervical range of motion; and atrophy, weakness, diminished reflexes, and hyperesthesia of the left arm.

Independent Medical Examiners Drs. Brooks and Coletti reviewed claimant's March 1990 myelogram. They noted it was suspicious for a C5-6 disc herniation, and recommended additional work-up of claimant's neck and arm, to include an EMG and MRI scan or postmyelographic CT Scan.

Claimant's accepted 1980 cervical injury was a muscle strain. Claimant's 1990 cervical injury has been diagnosed as a herniated disc at C5-6.

No order designating a paying agent issued pursuant to ORS 656.307.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

On review, SAIF does not challenge the Referee's responsibility conclusion. Nonetheless, noting that claimant filed his request for hearing after May 1, 1990 and the hearing was convened after July 1, 1990, SAIF contends the

1990 statutory changes to responsibility law apply. We disagree. Claimant's accepted 1980 cervical injury was a muscle strain. Claimant's 1990 cervical injury has been diagnosed as a herniated disc at C5-6. Where, as here, the second compensable injury does not involve the same condition but, rather, merely the same body part as the prior injury, Section 49 of SB 1197 is not applicable. Beverly R. Tillery, 43 Van Natta 2470, 2472 (1991). Accordingly, we too analyze this claim under case law in effect before the 1990 statutory changes to responsibility.

Responsibility

The Referee found claimant's February 1990 injury at F&C's insured independently contributed to a pathological worsening of his accepted cervical condition and, accordingly, responsibility for claimant's cervical condition shifts from SAIF to F&C.

We affirm and adopt the Referee's reasoning and conclusion as set forth in the "Conclusions of Law and Opinion" section of the Opinion and Order and "Discussion" section of the Order on Reconsideration with the following comment.

SAIF remains responsible for claimant's cervical condition unless work activities with F&C's insured independently contributed to a pathological worsening of claimant's accepted condition. See Mission Insurance Co. v. Dundon, 86 Or App 470, 472-73 (1987); Hensel Phelps Const. v. Mirich, 81 Or App 290, 293-94 (1986). If those activities independently contributed, however slightly, to a worsening of his condition, then F&C is solely responsible. Id.

On review, F&C asserts that there is no evidence of a pathological worsening of claimant's cervical condition and, in the alternative, that there is no evidence that any such worsening was caused by claimant's February 1990 injury at F&C's insured. We disagree.

Dr. Hacker, consulting neurologist, examined claimant following his February 1990 injury. He noted decreased cervical range of motion; and atrophy, weakness, diminished reflexes, and hyperesthesia of the left arm -- findings which were not present prior to the second injury. Thereafter, in March 1990, he performed a cervical myelogram. Whereas a March 1983 cervical myelogram revealed no abnormality, Dr. Wilken, the hospital radiologist and Dr. Hacker, respectively, interpret the 1990 myelogram as "highly suspicious" for disc herniation at C5-6 on the left, and "consistent" with cervical disc herniation at C5-6 on the left. In addition, Dr. Hacker has recommended claimant undergo cervical microdiscectomy and fusion. Independent examining physicians Brooks and Coletti interpret the myelogram as "inconclusive." However, they also note it is "suspicious" for abnormality at the C5-6 level, and recommend additional work-up of claimant's neck and arm, to include an EMG and MRI scan or postmyelographic CT Scan. On this record, we agree that SAIF has established that claimant's underlying cervical condition has worsened.

Only Dr. Hacker has expressed an opinion regarding the cause of claimant's worsened condition. After taking a thorough history and performing a complete examination, Dr. Hacker unequivocally concludes that claimant has cervical radiculopathy, disc herniation and nerve compression, and that his present medical condition was caused primarily by the February 1990 injury. Accordingly, we also find that claimant's work at F&C independently contributed to his current compensable condition. Consequently, responsibility for claimant's cervical condition shifts from SAIF to F&C.

Attorney Fee

F&C requested Board review, and sought to prevent the shifting of responsibility for claimant's current condition from SAIF to itself. Claimant's

aggravation rights had expired on the SAIF claim. Claimant's counsel participated on Board review and contended that the Referee's responsibility decision should be affirmed. Under these circumstances, we conclude that claimant's attorney is entitled to a fee for services on review under ORS 656.382(2), payable by F&C, the insurer that initiated Board review. See Marlene G. Schmidt, 43 Van Natta 1211 (1991); Joel D. Turpin, 42 Van Natta 1736 (1989).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $600 is a reasonable fee for claimant's counsel's services on review. 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 to claimant.

ORDER

The Referee's order dated December 11, 1990, as reconsidered February 22, 1991, is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $600, for services on review, payable by Fire & Casualty Insurance Company of Connecticut.

In the Matter of the Compensation of
PAT K. YOST, Claimant
WCB Case No. 89-12047
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Leahy's order which: (1) upheld the insurer's partial denial of claimant's current psychological condition; and (2) affirmed a Determination Order that awarded claimant no additional unscheduled permanent disability beyond a previous award of 10 percent (32 degrees). On review, the issues are compensability and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured her low back on June 14, 1986 while she was working as a CNA for American Nursing. Prior to her industrial injury, claimant had a long history of personal, family and psychological problems. (Ex. 1). A Determination Order awarded claimant 10 percent unscheduled permanent partial disability on March 17, 1987 for her low back injury. A second Determination Order dated October 21, 1987 awarded claimant temporary disability, but no additional permanent disability. On January 4, 1988, claimant was hospitalized for depression. (Ex. 55-1).

An October 17, 1988 Opinion and Order found claimant's psychiatric condition compensable. (Ex. 73A). This Opinion and Order was subsequently affirmed by both the Board and the Court of Appeals. On February 21, 1989, claimant was examined by Dr. Fortiner, a psychiatrist. Dr. Fortiner opined that claimant's need for treatment of her psychiatric condition is due to her longstanding psychiatric problems and personality disorder and not her compensable injury. (Ex. 74). Mr. Brown, who has been claimant's counselor for many years, agreed that claimant's psychological condition was present before her compensable injury, but opined that the injury did exacerbate her mental health condition. (Ex. 75).

On April 21, 1989, a third Determination Order awarded claimant no further temporary or permanent disability. (Ex. 77). On June 26, 1989, the insurer denied claimant's current need for treatment of her psychiatric condition as unrelated to her 1986 compensable injury. (Ex. 78).

Dr. White agreed with Dr. Fortiner and stated that claimant grossly fits a picture of severe personality disorder more than a true or pure depression. (Ex. 79).

At the first hearing in this matter, claimant delivered to her attorney a report by Dr. Segur (Ex. 80) and a report from Dr. Williamson (Ex. 81). In his first Opinion and Order the Referee declined to admit these documents. The Board issued an Order on Review (Remanding) instructing the Referee to admit Exhibits 80 and 81 and reconsider the compensability and extent of permanent disability issues in light of these exhibits. A hearing was held on February 8, 1991. The Referee admitted Exhibits 80 and 81 and issued his Opinion and Order on March 25, 1991.

CONCLUSIONS OF LAW AND OPINION

Compensability

Upon consideration of the newly admitted documents, the Referee concluded that they did not alter the outcome of this case.

To establish compensability of her current psychiatric condition, claimant must prove that her compensable injury is a material contributing cause of her need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). We conclude that claimant has sustained her burden of proof for the following reasons.

Dr. Fortiner opined that claimant's psychological problems and personality disorder long preexisted her minor compensable injury. Therefore, he opined that claimant's need for psychiatric treatment is not related to her compensable injury. Dr. Fortiner's opinion does not explain why claimant's current psychological condition is no longer related to her compensable injury. Rather, it indicates that claimant's psychological condition is not, and never has been, related to her industrial injury. Dr. Fortiner's opinion conflicts with the law of the case, which is that claimant's psychological condition is compensably related to her industrial injury. As a legal matter, Dr. Fortiner's opinion is wrong. Kuhn v. SAIF, 73 Or App 768 (1985). For this reason, we discount his opinion.

Dr. White relied on Dr. Fortiner's opinion. Because we do not find Dr. Fortiner's opinion persuasive, we likewise do not find Dr. White's opinion relying on Dr. Fortiner's views persuasive.

Dr. Williamson, claimant's psychologist, opined that work gave claimant her sense of worth and purpose. Dr. Williamson opined that the compensable injury set off a chain of symptoms culminating in depression, agoraphobia, and occasionally suicidal tendencies. Dr. Williamson opined that claimant needs ongoing psychotherapy. Based on this evidence, we find that claimant has met her burden to prove that her injury was a material contributing cause of her current need for psychological treatment.

Permanent Disability

Although we have set the denial of claimant's current condition aside, claimant requests that we rate the extent of her permanent unscheduled disability including her psychological condition. The parties do not dispute that

portion of the Determination order which found claimant medically stationary, with regard to her low back and psychological condition, as of February 21, 1989. Inasmuch as we find the record sufficiently developed regarding psychological impairment, we proceed to rate the extent of claimant's unscheduled permanent disability, including her compensable psychological condition.

The Referee found claimant not credible and "found nothing believable in the file" with which to evaluate claimant's permanent disability. The basis of the Referee's credibility finding was claimant's admission on cross-examination that she submitted a false reimbursement request for a prescription to the insurer. When the Referee bases his credibility finding on inconsistencies in the record, rather than claimant's demeanor while testifying, the Board may make its own assessment of claimant's credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Dean A. Grudzinski, 42 Van Natta 597, 598 (1990).

Although claimant's testimony at hearing with regard to the submission of the false reimbursement request was untruthful, we find no indication that her lack of truthfulness with regard to the false reimbursement request tainted her physician's impairment findings. Therefore, although we decline to alter the Referee's credibility finding, we proceed to consider the medical evidence of permanent impairment.

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 February 21, 1989, and her claim was closed by Determination Order on April 21, 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.

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 and Education

The appropriate value for claimant's age of 39 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's 12 years of formal education 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 the value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is always determined on the date of hearing. The position which claimant successfully performed during the ten years proceeding the date of hearing, which has the highest SVP level, was as a nurse's aide (DOT # 355.674-014). Therefore, the appropriate value for skills is 3. 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. See Larry L. McDougal, 42 Van Natta 1544 (1990).

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

Adaptability

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition 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).

Here, claimant is not working as a result of her compensable injury and no offer of employment has been made. Claimant's physical capacity is in the light category. Therefore, the appropriate adaptability value is 4. Former OAR 436-35-310(4)(c).

Claimant's 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 category. Thus, the appropriate adaptability value is 4. Former OAR 436-35-310(4)( ).

Impairment

There is a disparity in the evidence with respect to claimant's range of motion findings. We defer to the range of motion findings in the Medical Consultants Northwest report dated July 14, 1988. Claimant's impairment based on her loss of range of motion is 6.4 percent. We do not defer to Dr. Segur's report contained in Exhibit 80 because it does not set out claimant's current range of motion findings, but rather states they are consistent with his April 1987 exam. We find Dr. Segur's report to be conclusory in this regard.

The April 21, 1989 Determination Order did not award claimant any unscheduled permanent disability for her compensable psychological condition. Claimant contends that she is entitled to an impairment value of 5 percent pursuant to former OAR 436-35-400(4)(a), which provides for an impairment rating for a permanent state of psychoneurosis. This neurosis must be diagnosed by a psychiatrist or psychologist. There is no evidence that claimant's condition is permanent as required by former OAR 436-35-400(4), we conclude, therefore, that claimant is not entitled to any impairment value for her psychological condition.

Accordingly, claimant's total value for impairment is 6.4.

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 0 is added to his education value 3 the sum is 3. When that value is multiplied by claimant's adaptability value 4 the product is 12. When that value is added to claimant's impairment value 6.4 the result is 18.4 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, 19 percent.

Inasmuch as claimant has previously received an award of 10 percent unscheduled permanent disability for her compensable injury, she is not entitled

to the full 19 percent at this time, but rather, she is entitled to the additional 9 percent unscheduled permanent disability. See Ronald R. Buddenberg, 43 Van Natta 434 (1991); Gary A. Koch, 42 Van Natta 2777 (1990).

Attorney Fee/ Board Review

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 25, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning claimant's psychological condition, claimant's counsel is awarded an assessed attorney fee of $3,000, payable by the insurer. In addition to the prior Determination Order award of 10 percent (32 degrees), claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, giving her a total award to date of 19 percent (60.8 degrees) unscheduled permanent disability for her low back injury. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
LINDA M. AKINS, Claimant
WCB Case No. 90-22641
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Knapp's order that: (1) declined to award an assessed attorney fee for her counsel's services in obtaining rescission, prior to hearing, of the SAIF Corporation's denial of her low back injury claim; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. SAIF denied the claim on November 19, 1990. On December 13, 1990, claimant began losing time from work due to the low back injury. On December 28, 1990, claimant's attorney requested a hearing on SAIF's November 19, 1990 denial.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the

"litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Pre-Hearing Denial Rescission - Attorney Fees

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available for a denial rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if "an attorney is instrumental in obtaining compensation," even if a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540 3. Such is the case here.

The Referee also found that claimant's attorney was not entitled to an approved fee pursuant to OAR 438-15-030 because he concluded that claimant's attorney was not instrumental in initiating the request for the investigation which lead to the denial rescission.

We find that claimant's attorney's request for hearing preserved claimant's rights because SAIF rescinded the denial more than 60 days after the date of the denial. Therefore, by preserving claimant's rights, claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. Accordingly, an attorney fee for services prior to the hearing is warranted. However, we agree with the Referee that claimant's telephone call to SAIF initiated the investigation which was ultimately responsible for the rescission of the denial.

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 attorney's services prior to hearing concerning the compensability issue is $150, to be paid by the SAIF Corporation . In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record).

Penalties and Attorney Fees

Allegedly Unreasonable Conduct by SAIF

With the following supplementation, we adopt the Referee's opinion and conclusion that SAIF did not act unreasonably in denying claimant's claim, given the information it had at the time of the denial.

After receiving an 827 form from Dr. Clark in which claimant described her low back injury as occurring at work, Ms. Highberg, the claims adjuster, phoned the employer's risk management person who said he had no knowledge of any claim or injury to claimant. (Tr. 12, 17). On the basis of this information and the apparent gap between the injury and the first medical treatment, SAIF denied the claim.

Claimant argues that, prior to SAIF's denial, SAIF received an 801 form from the employer acknowledging that the injury occurred at work. Thus, claimant argues, SAIF's denial was unreasonable. However, Ms. Highberg testified that she received the 801 form after she denied the claim. She also testified that she was advised by SAIF's counsel not to bring the claims file to the

hearing. During the hearing, claimant's attorney determined that, although the 801 form in the record was not date stamped, the original 801 form in the claims file probably had a date stamp which would determine whether SAIF received that document before it issued its denial. (Tr. 11). However, claimant's attorney expressly waived any request to produce the claims file. (Tr. 18). Therefore, there is no evidence in the record to rebut Ms. Highberg's testimony.

Unreasonable Conduct by the Employer

The Referee found that the employer's actions were unreasonable, imputable to SAIF, and subject to a penalty for unreasonable resistance to the payment of compensation. We agree. However, he found that, at the time of the November 19, 1990 denial, there were no amounts "then due" upon which to base a penalty. We disagree.

The employer had knowledge of the claim on August 27, 1990, the day after the work injury. (Ex. 3). However, the employer initially told SAIF that claimant was not injured at work. On this basis, SAIF denied the claim on November 19, 1990. Sometime after November 8, 1990, the date the employer signed the 801 form, the employer reported to SAIF that the claim was work related. (Ex. 3).

An employer must report a claim to its insurer within five days after receiving notice or knowledge of the claim. ORS 656.262(3). The employer's conduct in initially denying that the claim was work related and in failing to report the claim in a timely manner is legally imputable to its insurer. See Nix v. SAIF, 80 Or App 656 (1986), rev den 303 Or 158 (1987). Hence, SAIF is deemed to have notice of the claim when its insured received notice on August 27, 1990. Because SAIF's denial was issued less than 90 days after its imputed knowledge of the claim, the denial was not untimely. ORS 656.262(6). However, given the imputed knowledge of the work-relatedness of the injury, the denial was unreasonable.

ORS 656.262(10)(a) provides, in pertinent part, that "[i]f the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amount then due." 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).

SAIF argues that any penalty on an unreasonable denial is computed as a percentage of the amounts due at the time of the hearing. SAIF also contends that, since the temporary disability compensation was paid before the hearing, there were no amounts due upon which to base a penalty. Claimant argues that she is entitled to a penalty based on the delay in payment caused by the unreasonable denial.

We find the present case analogous to Jeffrey D. Dennis, 43 Van Natta 857 (1991). There, the insurer unreasonably delayed denial of a claim which resulted in untimely payment of interim compensation. However, this interim compensation was paid before the untimely denial was issued. Thus, no amounts were due as of the date of the denial.

In Dennis, the insurer, relying on Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988), argued that only amounts due on the date of the denial were "amounts then due" for the purpose of penalty assessment. We interpreted Satcher less restrictively and concluded 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." Jeffrey D. Dennis, supra at 858. We based our conclusion, in part, on the fact that former ORS 656.262 expressly provided a penalty for unreasonable delay in payment of compensation. Therefore, we were unwilling to conclude that the statute also provided for a

cure after such a delay whereby the insurer could "pay up" just before issuing an untimely denial. Id.

The same reasoning applies here. The current version of ORS 656.262(10) contains the same provision for a penalty for unreasonable delay in payment of compensation. Here, the unreasonable denial delayed payment of temporary disability compensation. The fact that SAIF rescinded the denial and paid this compensation before the hearing does not negate the fact that payment was delayed. The delay period continued until SAIF rescinded its denial. Thus, the temporary disability compensation due at the time SAIF rescinded its denial is an amount "then due" for penalty purposes. See also Walter E. McCarthy, 43 Van Natta 593 (1991) (where denial was both untimely and unreasonable, the Board awarded a penalty of 25 percent of the disability benefits due at the time the insurer withdrew its denial).[1] Accordingly, we assess a penalty of 25 percent of that amount.[2]

Claimant argues that she is also entitled to a separate attorney fee pursuant to ORS 656.382(1). We disagree. Where, as here, a single unreasonable action is relied upon to support both a penalty and attorney fee, only ORS 656.262(10) applies. Accordingly, pursuant to ORS 656.262(10)(a), one-half of the additional amount shall be awarded to claimant's attorney, in lieu of an attorney fee. See Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991).

ORDER

The Referee's order dated March 29, 1991 is reversed in part and affirmed in part. That portion which declined to award an assessed attorney fee for services concerning the SAIF Corporation's rescission of its denial prior to hearing is reversed. For services rendered in conjunction with the rescission of the denial, claimant's counsel is awarded an assessed attorney fee of $150, payable by SAIF. That portion of the order which declined to award a penalty pursuant to ORS 656.262(10) is reversed. Claimant is awarded a penalty of 25 percent of the temporary disability benefits due when SAIF rescinded its November 19, 1990 denial of claimant's low back strain on January 30, 1991. Claimant's attorney shall receive one-half of that penalty in lieu of an attorney fee. The remainder of the order is affirmed.

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[1] In the ordinary "unreasonable denial" case, the employer or insurer does not rescind its denial prior to hearing. In such a case, we calculate the financial "damage" to the claimant as of the hearing in order to assess a penalty based on the full amount of compensation due and owing to claimant by virtue of the denial. Here, the insurer ultimately rescinded its unreasonable denial but after almost two months during which claimant was without compensation because of the unreasonable denial. Clearly, it would not serve the purpose and policy of ORS 656.262(10) to calculate the amount "then due" as of the hearing, where the unreasonable denial is rescinded prior to the hearing. By rescinding the denial prior to hearing, the insurer has clearly limited the amount of its liability to claimant for a penalty. The rescission did not, however, deprive claimant of a valid claim for a penalty based on the period before the rescission during which she was without the compensation to which she was entitled because of the unreasonable denial.

[2] ORS 656.262(3), which requires prompt reporting of claims to its insurer by an employer, also states:

> "Failure to so report subjects the offending employer to a charge for reimbursing the insurer for any penalty the insurer is required to pay under subsection (10) of this section because of such failure."

In the Matter of the Compensation of
LUCAS DeLEON, Claimant
WCB Case Nos. 90-21214 & 90-21549
ORDER ON REVIEW
Max Rae, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Steven Cotton (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Holtan's order which: (1) upheld SAIF/Golden Valley Farms' denial of his current lumbar and cervical spine condition; (2) upheld SAIF/Bob Cheyne Farms' denial of his "new injury" claim for a sprain of the sacroiliac ligament; and (3) declined to award penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and related attorney fees.

We affirm and adopt the Referee's order with the following supplementation concerning the claim against SAIF/Golden Valley Farms.

The Referee applied ORS 656.005(7)(a)(B) and concluded that claimant's March 19, 1987 compensable injury "made neither a major contribution, nor any contribution," to his current low back and cervical condition.

Because we conclude that the March 19, 1987 injury was not even a material contributing cause of claimant's current low back and cervical spine condition, we need not consider whether ORS 656.005(7)(a)(B) applies in this situation.

Dr. Bain took x-rays of claimant's low back and cervical spine and opined that claimant's current symptoms are due to osteoarthritis, and are not related to the March 19, 1987 injury. Dr. Bain's opinion is supported by the July 14, 1987 report of the Western Medical Consultants. They opined that claimant's "real problem is degenerative spine disease related to his age which is symptomatic with activity." We find the opinions of Dr. Bain and the Western Medical Consultants to be well reasoned and based on complete information. We, therefore find these opinions to be persuasive. Somers v. SAIF, 77 Or App 259, 263 (1986).

The Referee found the opinion of Dr. Stearns unpersuasive. We also find Dr. Stearns unpersuasive. Dr. Stearns fails to address the impact of claimant's osteoarthritis on his current back symptoms. Based on this record, we conclude that claimant has failed to show that his March 1987 injury remains a material contributing cause of his current need for treatment.

ORDER

The Referee's order dated April 30, 1991 is affirmed.

In the Matter of the Compensation of
LUIS E. GONGORA, Claimant
WCB Case No. 90-10314
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Seifert's order which: (1) upheld the insurer's partial denial of his psychological and current physical conditions, and (2) decreased his unscheduled permanent disability award from 19 percent (60.8 degrees), as awarded by Determination Order, to 12.5 percent (41.6 degrees) unscheduled permanent partial disability. In its brief, the insurer contends that claimant's unscheduled permanent partial disability should be reduced to zero. On review, the issues are the propriety of the denial and extent of unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Physical Condition

Claimant suffered a compensable head and low back injury in December 1988. Since that time, he has complained of debilitating low back pain, and has been examined by several doctors. At hearing, claimant also complained of pain in his head, stomach, ears, neck, hips, ankles, knees, thigh, lungs and arms. On July 25, 1990, the insurer reaffirmed its acceptance of the original head and back injury claim, but otherwise denied claimant's current physical problems as not being compensably related to the 1988 compensable injury.

To establish entitlement to compensation for medical services, claimant must prove a causal relationship between his need for medical services and his compensable injury. Jordan v. SAIF 86 Or App 29, 32 (1987). Here, the Referee concluded, and we agree, that claimant has failed to carry his burden of proof.

The great weight of the medical evidence does not even verify the existence of any continued physical problems resulting from the 1988 incident. Dr. Howell, osteopath, opined that there was no correlation between claimant's subjective complaints and the objective physical findings. In his deposition, he stated that claimant's low back pain was in an unusual area, that claimant displayed dramatic pain behavior, such as gasping, groaning, and moaning, which is not usual in back strain sufferers, and which indicated the presence of non-physical factors affecting claimant's condition. He noted that claimant had a positive Waddell sign which might indicate a non-physical cause of claimant's pain, and explain his complaints of diffuse pain when localized pain is to be expected of someone with a sprain or strain injury.

Dr. Benz, an orthopedic surgeon, and one of claimant's treating physicians, concurred with Dr. Howell's opinion that there was no correlation between claimant's subjective complaints and objective physical findings. In a later report, he agreed with Dr. Howell that there was no evidence of ongoing effects from the 1988 compensable injury. He also concurred that there were no musculoskeletal abnormalities which could account for claimant's complaints, and that claimant was as physically capable of working now as he was before the 1988 injury. (Ex. 51).

Claimant relies primarily on Dr. Benz, who opined that the 1988 injury was the major contributing cause of claimant's physical condition and disability. However, in that same report, as noted above, Dr. Benz agreed with Dr. Howell that there were no ongoing effects of the 1988 injury and that claimant's physical condition had returned to its pre-injury status. Although Dr. Benz's report is internally inconsistent, its specifics and predominate weight support the insurer's case. Dr. Benz's report is insufficient to carry claimant's burden of proof.

The only other medical evidence comes from Dr. Romero, who also treated claimant. Dr. Romero opined that claimant is primarily depressed and that his head injury may have contributed to his depression. (Ex. 52). Dr. Romero took exception only with the tone of Dr. Howell's report. He did not disagree with its specifics.

In summary, the preponderance of the evidence establishes that claimant does not have any physical problem which is compensably related to claimant's 1988 accepted injury. The Referee properly upheld the physical conditions portion of the insurer's denial.

Psychological Condition

The insurer also issued a partial denial of claimant's current psychological condition. The Referee concluded that claimant has not proven that he has a compensable psychological condition requiring medical services as a result of the compensable injury. We agree.

To establish compensability of a psychological condition arising as a consequence of the 1988 compensable injury, claimant must prove by a preponderance of the evidence that the compensable injury is the major contributing cause of the psychological condition. ORS 656.005(7)(a)(A). Of course, as a threshold matter, he must first establish that he has a psychological condition that is disabling and requires medical treatment.

The Referee concluded that claimant failed to carry his burden of proof. We agree.

Dr. Colbach, psychiatrist, examined claimant for the insurer as part of an Orthopaedic Consultants panel. The psychological evaluation was arranged because the physicians who treated or examined claimant were unable to find any physical cause for claimant's subjective complaints.

Dr. Colbach opined that claimant was "making too much of whatever true aches and pains he has." He found claimant medically stationary with regard to his psychological condition and did not think that claimant had any significant psychiatric problem due to his industrial injury. (Ex. 20-3). In a later report, Dr. Colbach opined that the work injury was a very minor event, which possibly played no role in claimant's psychological problems. He opined that claimant did not have any psychological problem which required medical treatment. (Exs. 20, 49).

Dr. Howell, who is not a psychiatrist, opined that claimant does not have a psychological condition. Dr. Romero, also not a psychiatrist, opined that claimant was depressed and that his depression may have been caused by the 1988 injury.

Claimant relies primarily on the opinion of Dr. Torres, psychologist. Dr. Torres evaluated claimant on a referral from Dr. Benz, who was unable to find any physical reason for claimant's complaints.

Dr. Torres opined that claimant was depressed secondary to the 1988 injury which claimant perceives as incapacitating. However, Dr. Torres did not find that claimant required treatment for his depression. Instead, he opined that claimant needed to return to work, and that if he did so, his florid pain complaints would in all likelihood diminish. (Ex. 18).

Thus, there is no evidence in the record that claimant has a psychological condition which is disabling and which required treatment. Accordingly, the Referee properly upheld the insurer's denial.

Assuming arguendo that claimant suffers from a disabling psychological condition, we would still uphold the insured's denial as claimant has not established that his compensable injury is the major contributing cause of his psychological condition. In reaching this conclusion, we rely on the well-reasoned opinion of Dr. Colbach

Unscheduled Permanent Disability

The Referee reduced claimant's disability award to 12.5 percent. The Determination Order awarded claimant 19 percent unscheduled permanent partial disability. In its brief, the insurer argues that on de novo review the Board should reduce the permanent partial disability award to zero because the Referee found claimant had no impairment and allowed claimant an award of permanent disability based solely on educational and vocational factors. We agree.

Where the claimant fails to establish any measurable impairment resulting from his or her compensable injury/condition, no award of disability is allowed. Former OAR 436-35-010(2)(b), OAR 436-35-280(1).

Here, claimant has failed to establish measurable impairment resulting from his compensable injury. Therefore, we find that claimant has failed to establish entitlement to an award of permanent disability.

We conclude after a de novo review of the record that claimant has proven no impairment due to his December 1988 injury. The Orthopaedic Consultants found gross interference making evaluation almost impossible. (Ex 21). In their second examination of claimant, Orthopaedic Consultants found that the language barrier and claimant's gross pain behavior made it difficult to assess the nature of impairment. This was so even though an interpreter was present. (Ex 34-4). Dr. Howell opined that claimant had no permanent impairment. He opined that claimant's reduced range of motion was voluntarily controlled and not an indication of any underlying pathological condition. (Ex 41). Claimant's chiropractor, Dr. Beeson, and orthopedic surgeon, Dr. Benz, concurred with Dr. Howell's report. Dr. Benz again concurred specifically with Dr. Howell's statements that claimant had no permanent impairment resulting from his December 1988 injury and that claimant was as physically capable of working as he was prior to the December 1988 injury. (Ex 51-4).

Claimant was evaluated by Dr. Lubcke, a chiropractor at Jennings Lodge Chiropractic Center. Dr. Lubcke opined: "I am somewhat uneasy with the inconsistencies present on physical and mechanical testing." Dr. Lubcke also stated that some functional overlay and interference could be present in the testing process. In spite of these concerns, Dr. Lubcke concluded that functional overlay did not interfere with the testing process.

We conclude that, based on the medical reports summarized above, claimant has not proven he has impairment due to lost ranges of motion.

We agree with the Referee that there is no evidence that claimant's disc bulge was caused by his compensable injury. Therefore, no value may be given for his disc bulge. See Ruben D. Carlos, 43 Van Natta 605 (1991); Daniel G. Huff, 42 Van Natta 2805 (1990).

We conclude that claimant has failed to establish any measurable impairment resulting from his compensable injury. Therefore, no award of disability is allowed. Former OAR 436-35-010(2)(b), former OAR 436-35-280(1).

ORDER

The Referee's order dated March 13, 1991 is affirmed in part and reversed in part. In lieu of the Referee's and Determination Order award of unscheduled permanent disability, claimant is awarded zero percent unscheduled permanent disability. That portion of the Referee's order which upheld the insurer's denial of claimant's psychological condition is affirmed. In addition, that portion of the insurer's denial which denied claimant's current physical condition as no longer being related to his compensable injury is upheld.

In the Matter of the Compensation of
JOHN M. SMITH, Claimant
Own Motion No. 91-0686M
OWN MOTION ORDER
Bischoff & Strooband, Claimant Attorneys
Employers Insurance of Wausau, Insurance Carrier

The insurer submitted claimant's claim for an alleged worsening of his April 19, 1976 low back injury. Claimant's aggravation rights expired on December 19, 1982. The insurer has denied the compensability of and responsibility for claimant's current right shoulder rotator cuff tear condition and resultant surgery of September 17, 1991. It also opposes the reopening of claimant's claim for payment of temporary disability compensation, contending that claimant has removed himself from the work force.

We may exercise our own motion authority and reopen claimant's claim for additional temporary disability compensation if he has sustained a worsening of his compensable injury requiring either inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS 656.278(1)(a). However, at the present time, litigation is pending regarding compensability of claimant's current medical treatment (WCB Case No. 91-17460). The Board routinely postpones action on own motion matters until final resolution of pending litigation on related issues is resolved.

Nevertheless, postponement is not necessary where the claimant is not entitled to own motion reopening. A claimant does not qualify for the payment of temporary disability compensation unless he was in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). The insurer contends that claimant has withdrawn from the work force. By a November 22, 1991 Order on Review (WCB Case No. 88-09368) the Board concluded that claimant had not worked since 1976, with the exception of a one-week trial period and that he was not willing to work. We, accordingly, conclude that claimant has withdrawn from the work force. Consequently, we deny claimant's request for temporary disability compensation. See id.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY McSPERITT, Claimant
WCB Case No. 89-10041
ORDER ON REMAND
Jolles, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Roseburg Forest Products v. McSperitt, 108 Or App 288 (1991). The court has reversed our order that affirmed a Referee's order which set aside an occupational disease denial of claimant's hearing loss claim. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991), and Liberty Northwest Ins. Corp. v. Damm, 107 Or App 764 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" as contained in the Referee's order with the following supplementation. Claimant's work exposure for the self-insured employer was the major contributing cause of his binaural hearing loss.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's work exposure for the employer was the major cause of the hearing loss in both of claimant's ears, the Referee held that claimant's occupational disease claim was compensable. We affirmed with the following supplementation. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that claimant need only establish that his work exposure was a material contributing cause of his hearing loss.

The court has recently held that to establish the compensability of an occupational disease claim under former ORS 656.802, a claimant must establish that his work activities were the major contributing cause of his condition. Liberty Northwest Insurance Corp. v. Damm, supra; Aetna Casualty Co. v. Aschbacher, supra. In light of those recent holdings, the court has reversed our order and remanded for reconsideration.

After conducting our reconsideration, we conclude that claimant's work exposure was the major contributing cause of his hearing loss. In reaching this conclusion, we rely upon claimant's credible testimony and the opinion offered by Dr. Burkett, claimant's attending physician. As was the Referee, we are persuaded by Burkett's opinion that claimant's exposure to noise while working for the employer was the major contributing cause of his hearing loss.

Accordingly, on reconsideration, we affirm and adopt the Referee's order dated September 15, 1989. Our prior $875 attorney fee award for services on Board review is republished.

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY McSPERITT, Claimant
WCB Case No. 89-10041
SECOND ORDER ON REMAND
Jolles, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The self-insured employer requests reconsideration of our October 30, 1991 Order on Remand that affirmed, with supplementation, a Referee's order setting aside the employer's denial of claimant's occupational disease claim for hearing loss. Contending that our order neglected to address several Board decisions concerning hearing loss claims, the employer reiterates that claimant has failed to establish that his work exposure for the employer was the major contributing cause of his hearing loss.

To varying degrees, each of the cases upon which the employer relies involved medical opinions which declined to attribute the claimants' hearing loss to work exposure because the claimants wore ear protection while working. Here, in contrast, the sole medical opinion acknowledges that claimant wore ear protection while performing his work activities, but continues to reach the conclusion that claimant's work exposure was the major contributing cause of his hearing loss. For the reasons articulated by the Referee, in addition to claimant's credible testimony concerning his on and off work exposures, we continue to find this opinion persuasive. Consequently, we remain persuaded that claimant's hearing loss claim is compensable.

Accordingly, we withdraw our October 30, 1991 order. On reconsideration, as supplemented herein, we adhere to and republish our October 30, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ERNEST C. RICHTER, Claimant
WCB Case Nos. 88-04556, 86-13711 & 85-12160
ORDER ON REMAND
Emmons, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Richter v. Pacific Auto Body & Paint, 108 Or App 470 (1991). The court has reversed that portion of our order, Ernest C. Richter, 42 Van Natta 955 (1990), which held that claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) when Argonaut Insurance rescinded its compensability denial of claimant's chiropractic treatment prior to hearing. Relying on the amendments to ORS 656.386(1) as adopted by SB 540, the court has reversed that portion of our order and remanded for an award of attorney fees.

FINDINGS OF FACT

We republish the "Findings of Fact" and "Ultimate Findings of Fact" contained in our prior order with the following supplementation. Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee held that claimant's attorney was entitled to an attorney fee for services rendered in securing the rescission of Argonaut's compensability

denial prior to hearing. After considering claimant's attorney's statement of services in light of the factors set forth in former OAR 438-15-010(2) (now section (4)), the Referee found that $800 was a reasonable attorney fee. Finally, the Referee concluded that the fee was payable from claimant's compensation, rather than by Argonaut.

Claimant requested Board review, contending that the Referee had erred in holding that the attorney fee should be paid from claimant's compensation. Claimant did not contest the amount of the Referee's attorney fee award. Rather, he requested that the Referee's order be modified to direct that claimant's attorney fee be insurer-paid.

Relying on Duane L. Jones, 42 Van Natta 875 (1990), we affirmed and adopted this portion of the Referee's order. Ernest C. Richter, supra. The court has reversed. In light of the legislature's amendment to ORS 656.386(1), the court has held that claimant is entitled to an insurer-paid attorney fee. Consequently, the court has remanded for such an award.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee concerning the rescission of Argonaut's chiropractic compensability denial prior to hearing is $800, to be paid by Argonaut. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's affidavit of services rendered), the complexity of the issue, and the value of the interest involved. We further note that, on review, claimant only contested the source, not the amount, of the Referee's attorney fee award.

Accordingly, on reconsideration, that portion of the Referee's order which awarded claimant's attorney a $800 fee is modified. Rather than being payable from claimant's compensation, as previously granted by the Referee, the $800 attorney fee is payable by Argonaut in addition to claimant's compensation. Therefore, in the event that claimant's attorney has already received the $800 fee from claimant's compensation, Argonaut shall pay claimant the $800 as reimbursement for the fee.

IT IS SO ORDERED.

January 23, 1992 Cite as 44 Van Natta 119 (1992)

In the Matter of the Compensation of
HELEN S. LONG, Claimant
WCB Case No. 90-17164
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Tenenbaum.

The SAIF Corporation requests review of Referee Black's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability.

We affirm and adopt the Referee's order with the following comment. On review, SAIF contends that, even assuming that claimant's condition is compensable, the surgery performed by Dr. Smith was not a compensable medical service under ORS 656.245. We find no evidence in the record that SAIF properly raised

that issue before the Referee. Accordingly, we decline to address it on review. See Stevenson v. Blue Cross, 108 Or App 247 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the compensability issue is $1,000, to be paid by the SAIF Corporation. 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 February 21, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

January 23, 1992 Cite as 44 Van Natta 120 (1992)

In the Matter of the Compensation of
KENNETH L. STUART, Claimant
Own Motion No. 90-0532M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Welch, et al., Claimant Attorneys
The Farmers Insurance Group, Insurance Carrier

Claimant requests review of the carrier's October 8, 1991 Notice of Closure which closed his claim with an award of temporary disability compensation from November 14, 1990 through September 30, 1991. The carrier declared claimant medically stationary as of September 30, 1991. Claimant contends that the insurer prematurely closed his claim and that he is entitled to additional compensation.

An insurer is required to continue paying temporary disability compensation until claimant is medically stationary and the claim is closed; claimant returns to regular or modified work; the attending physician gives claimant a written release to return to regular work; or the attending physician gives claimant a written release to return to modified work, such employment is offered in writing to claimant and claimant fails to begin such employment. OAR 438-12-035(2).

The insurer stated that claimant reported on August 22, 1991 that he had been released for modified work. By an August 7, 1991 chart note, Dr. Becker recommended that claimant return to work effective August 12, 1991, with restrictions on heavy lifting, twisting, bending or carrying. However, there is no evidence that claimant actually returned to work, nor is there evidence that employment was offered in writing to claimant and claimant failed to begin that employment. Accordingly, the insurer was required to continue paying temporary disability compensation until claimant became medically stationary and the claim was closed. Consequently, the question before us is whether claimant was medically stationary at the time of claim closure.

An injured worker is considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Dr. Nichols, who performed an independent medical examination on September 30, 1991, reported that claimant continued to have pain in the mid low back and pain in both legs, right greater than left.

Nichols also reported that claimant had been receiving physical therapy three times a week for the past eight months, but was unsure whether the physical therapy was helping him much. Nichols opined that claimant's condition appeared to be stable, that claimant had had less than optimal results from multiple back surgeries, and that it was extremely unlikely that further back surgery would be indicated or beneficial to claimant. He also opined that additional physical therapy would not be of benefit. (Letter of September 30, 1991.)

Dr. Becker, claimant's treating physician, noted on September 11, 1991 that claimant continued to have episodic flare-ups of pain to his leg. A physical examination demonstrated no significant change in claimant's condition. However, Becker recommended an MRI "to finally diagnose [claimant's] situation to see if there is any remediation possible and to facilitate final determination of his medical condition." Becker planned to see claimant after completion of the MRI. However, there is no evidence that the MRI was pursued and performed.

Here, even though there is no evidence that Dr. Nichols' report was provided to Dr. Becker for his response, it does not appear to us that Becker expected claimant's condition to materially improve with medical treatment or the passage of time. First, Dr. Becker noted that claimant had been experiencing episodic flare-ups in his right leg. Second, he did not explain what he expected to find from the MRI, aside from "possible remediation". We do not interpret this phrase to mean an expectation of material improvement. Furthermore, Becker's physical examination revealed no change in claimant's condition. In addition, claimant did not report any improvement from his physical therapy treatments. Thus, it does not appear that Dr. Becker has an expectation of improvement as a reason for continuing treatment.

Based on this record, we find that, at the time of claim closure, no further material improvement was reasonably expected from medical treatment or the passage of time. We therefore conclude that claimant became medically stationary on September 30, 1991 and affirm the insurer's claim closure in all respects.

IT IS SO ORDERED.

January 23, 1992 Cite as 44 Van Natta 121 (1992)

In the Matter of the Compensation of
SHARON J. TRUE, Claimant
WCB Case No. 89-16466
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Baker's order which held that claimant was not entitled to an assessed attorney fee under ORS 656.386(1) when the SAIF Corporation rescinded its denial of claimant's hepatitis claim. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On August 21, 1989, claimant's attorney filed a request for hearing concerning SAIF's June 30, 1989 denial of the claim.

At claimant's attorney's request, claimant's physician submitted a report stating, within a reasonable medical probability, that claimant contracted hepatitis at her work place. (See Exs. 7, 8).

On December 8, 1989, the day of the hearing, SAIF rescinded its denial and accepted the claim for hepatitis. As a result of SAIF rescinding the denial, there was no hearing concerning compensability of the claim.

Claimant's attorney was instrumental in obtaining compensation for claimant.

CONCLUSIONS OF LAW AND OPINION

The Referee held that claimant was not entitled to an assessed attorney fee based on Jones v. OSCI, 107 Or App 78 (1991), which held that former ORS 656.386(1) provided no basis for an award of insurer-paid attorney fees to a claimant when a carrier withdraws its denial prior to hearing. The Court of Appeals subsequently allowed reconsideration in that case and withdrew its opinion. Jones v. OSCI, 108 Or App 230, 232 (1991). The court's action was based on the 1991 amendment to ORS 656.386(1) providing that if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Id.

The order in this case did not become final before the effective date of the 1991 act, and therefore this case comes under the amended statute. SB 540, 3. Moreover, claimant's attorney submitted a hearing request concerning SAIF's denial and elicited a medical report concerning claimant's hepatitis condition and its relationship to her work activities. We therefore conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of SAIF's denial prior to the scheduled hearing and that claimant is entitled to an insurer-paid attorney fee under ORS 656.386(1). See Thomas D. Olive, 43 Van Natta 1881, 1882-83 (1991).

SAIF concedes that claimant is entitled to an attorney fee under ORS 656.386(1). SAIF contends, however, that claimant is not entitled to attorney fees on Board review under ORS 656.382(2) since claimant's right to attorney fees was the only issue on review and claimant's right to compensation was not at risk. We agree. Dept. of Justice, Inmate Ins. Fund v. Hendershott, 108 Or App 584 (1991).

After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable attorney fee concerning the rescission of SAIF's denial is $1,600, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved. We note that claimant's counsel is not entitled to an assessed fee for those services directed to the fee issue, as opposed to those services leading to SAIF's rescission of its denial. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The Referee's order dated May 20, 1991 is reversed. Claimant's attorney is awarded a reasonable insurer-paid attorney fee of $1,600 for services in connection with SAIF's pre-hearing rescission of its denial, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DIANA M. WRIGHT, Claimant
Own Motion No. 91-0623M
OWN MOTION ORDER
Pozzi, et al., Claimant Attorneys
EBI Companies, Insurance Carrier

The insurer submitted claimant's claim for an alleged worsening of her November 25, 1980 compensable low back injury. Claimant's aggravation rights expired on July 28, 1986. Claimant is requesting temporary disability compensation for her current cervical and thoracic and lumbar condition. The insurer opposes reopening of the claim on the ground that no surgery or hospitalization has been requested.

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

Here, Dr. Moore, claimant's treating physician, stated that further medical treatment for claimant's current condition is contraindicated, as she experienced only a minor flare in symptoms. Thus, the record fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we are not authorized to grant claimant's request for reopening. Accordingly, we deny the request for own motion relief.

Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DORIS KLAGER-HERMEN, Claimant
WCB Case No. 91-15474
ORDER DENYING MOTION TO DISMISS
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Claimant has requested Board review of Referee Schultz's November 29, 1991 "Order of Dismissal," which found that the Hearings Division lacked jurisdiction to consider the issues raised by claimant's hearing request. The self-insured employer has moved for dismissal of claimant's request for Board review, contending that the request is "premature" and that "exclusive jurisdiction of the issue currently resides with the Medical Director." We deny the motion to dismiss.

FINDINGS OF FACT

In October 1991, claimant requested a hearing, raising as issues: (1) unreasonable refusals to pay medical bills and to permit the choice of an out-of-state attending physician; and (2) penalties and attorney fees. Thereafter, the employer moved for dismissal, contending that the Hearings Division lacked jurisdiction to consider the issues raised by claimant's hearing request.

On November 29, 1991, the Referee issued his Order of Dismissal. Finding that "the issues raised by claimant in this case would fall within the exclusive jurisdiction of the director," the Referee dismissed claimant's request for hearing.

On December 23, 1991, claimant mailed, by certified mail, to the Board her request for review of the Referee's November 29, 1991 order. Included with claimant's request was a certification that a copy of the request had been mailed to the employer's counsel on December 23, 1991.

CONCLUSIONS OF LAW AND OPINION

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, as a result of the Referee's order, claimant's request for hearing concerning the issue of medical services was dismissed. Thus, at least as a procedural, if not a substantive matter, the order had the potential of impacting claimant's entitlement to compensation. In that respect, the order is an appealable final order. Donald L. Lowe, 41 Van Natta 1873 (1989).

Inasmuch as claimant timely requested Board review, the Referee's order has not become final. See ORS 656.289(3). Consequently, we hold that we have authority to consider the matters raised by claimant's request for Board review of that order.

As a result of this order, the following revised briefing schedule shall be implemented. Claimant's appellant's brief will be due 21 days from the date of this order. The employer's respondent's brief will be due 21 days from the date of mailing of claimant's appellant's brief. Claimant's reply brief shall be due 14 days from the date of mailing of the employer's respondent's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD L. RUSHTON, Claimant
WCB Case Nos. 90-18342, 90-20033, 90-20032 & 90-16159
ORDER ON REVIEW
Smith & Smith, Claimant Attorneys
Kevin L. Mannix, Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Liberty Northwest, on behalf of Cascade Block, requests review of those portions of Arbitrator Mongrain's decision that: (1) set aside Liberty's (Cascade Block's) denial of claimant's "new injury" claim for a low back condition; and (2) upheld Liberty's (Jackson County School District's) denial of claimant's aggravation claim for the same condition. In its respondent's brief, Liberty (Jackson County) requests that we correct a clerical error in the Arbitrator's decision, which states that Liberty (Jackson County), the nonresponsible carrier, was responsible for the Arbitrator's $1,400 attorney fee award. On

review, the issue is responsibility. Reviewing for questions of law pursuant to ORS 656.307(5), we affirm and correct the clerical error.

We affirm the Arbitrator's "Opinion" and "Conclusion of Law" with the following supplementation.

We have interpreted Section 49 of the amended law to mean that, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, in this case, Jackson County School District, as the last insured against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, Jackson County School District has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for Cascade Block.

The Arbitrator concluded that the medical record, supported by objective findings, established that claimant sustained an independent accidental low back injury in 1990 while working for Cascade Block that was a material contributing cause of his disability and need for treatment. See ORS 656.005(7)(a). Accordingly, the Arbitrator found that responsibility shifted from Jackson County School District to Cascade Block.

Cascade Block, however, argues that, for purposes of determining whether claimant sustained a "new compensable injury" under the amended responsibility law, we must apply ORS 656.005(7)(a)(B). That statute provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or 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." Or Laws 1990 (Special Session), ch. 2, 3.

Cascade Block contends that the 1989 injury with Jackson County amounts to a "preexisting condition" for purposes of ORS 656.005(7)(a)(B). In addition, Cascade Block asserts that claimant's 1990 injury while in its employ has combined with the preexisting condition from the 1989 injury, resulting in claimant's current condition. Therefore, Cascade Block argues that claimant did not experience a "new compensable injury" under the amended responsibility law unless the 1990 injury with Cascade Block is the major contributing cause of the resulting condition. We disagree.

As we recently held in Rosalie S. Drews, 44 Van Natta 36 (1992), ORS 656.005(7)(a)(B) is not applicable in the responsibility context. We reasoned that ORS 656.005(7)(a)(B) does not determine compensability of the initial injury, but rather limits a carrier's liability for continuing disability or need for medical services. Rosalie S. Drews, supra; Bahman M. Nazari, 43 Van Natta 2368 (1991). Only after initial compensability has been favorably decided do we inquire, pursuant to ORS 656.005(7)(a)(B), whether the compensable injury has combined with a preexisting disease or condition. Rosalie S. Drews, supra. Thus, compensability of further disability or need for treatment is a separate issue, the resolution of which is not relevant to the assignment of responsibility question. Id.

Here, it is not Jackson County School District's burden to establish that the 1990 injury was the major contributing cause of claimant's condition. Jackson County School District's burden went no further than proving material

contributing causation in order to establish a new compensable injury while claimant worked for Cascade Block. Inasmuch as the Arbitrator found that claimant had sustained a new compensable injury under a "material contributing cause" standard, it follows that responsibility for the claim shifts to Cascade Block.

Accordingly, since we find no error of law in the Arbitrator's decision, we affirm the determination that responsibility for claimant's low back condition rests with Liberty Northwest (Cascade Block).

As to the clerical error identified in Liberty's (Jackson County's) brief, we note that the Arbitrator concluded that Liberty (Cascade Block) was the responsible carrier. As the responsible carrier, the Arbitrator stated in the "Opinion" section of his decision that Cascade Block was responsible for paying claimant's attorney fee award. However, in the "Order" section of his decision, the Arbitrator mistakenly listed Liberty (Jackson County) as the carrier responsible for the fee. We correct this clerical error.

ORDER

The Arbitrator's decision dated March 25, 1991 is affirmed. A clerical error is corrected in the decision to provide that Liberty Northwest (Cascade Block), not Liberty Northwest (Jackson County), shall pay claimant's $1,400 attorney fee award for services at hearing.

In the Matter of the Compensation of
DENNIS C. BUSH, Claimant
WCB Case No. 90-19369
ORDER ON REVIEW
Schouboe & Furniss, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Moller.

Claimant requests review of that portion of Referee Galton's order that awarded 14 percent (44.8 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order had awarded no permanent disability. In its respondent's brief, the insurer argues that the Determination Order should be affirmed. The issue on review is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. For two weeks in December 1990, claimant returned to work at a job requiring light/medium physical capacity. (Tr. 16). He did not leave this job due to his injury.

CONCLUSIONS OF LAW AND OPINION

We note, preliminarily, that under the applicable law, we rate disability as of the date of hearing, not as of the date of claim closure. The amendments to ORS 656.283(7) and 656.295(5), which create a different rating principle, do not apply because claimant became medically stationary before July 1, 1990. See Or Laws 1990, Ch. 2, Sec. 54(3). Stephen A. Roberts, 43 Van Natta 1815 (1991).

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 April 18, 1990, and his claim was closed by Determination Order on April 25, 1990, 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.; WCD Admin. Order 1-1989. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

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 and Education

The parties do not dispute the values assigned by the Referee for claimant's age (0) and his formal education (0). Former OAR 436-35-290; former OAR 436-35-300(3).

Skills

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 as a truck driver, flatbed (DOT # 905.663-014) which has a SVP value of 4. Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

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).

Claimant argues that he is entitled to a training value of 1 based on his testimony that all of the jobs he has performed over the last ten years are entry level jobs. We disagree and find that the record establishes that he has demonstrated competence in a specific vocational pursuit, that of a truck driver. (Exs. 1, 18-2). Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Adding the values for formal education (0), skills (3), and training (0) results in a total education value of 3.

Adaptability

The Referee assigned an adaptability factor of 1. Claimant argues that he is entitled to an adaptability factor of at least 2.5 pursuant to former OAR

436-35-310(4), because, he argues, he is not working due to his compensable low back injury. We agree that if claimant returned to work but was unable to remain on the job because of his compensable injury, the adaptability factor would be determined pursuant to former OAR 436-35-310(4). George A. Ferguson, 44 Van Natta 11 (1992); Donna L. Bartruff, 42 Van Natta 2784 (1990).

However, the record does not establish these facts. Claimant worked for about two weeks in December 1990 at a cabinet shop. He testified that one of the reasons he quit this job was that his back worsened. (Tr. 16). However, he also testified that the shop was a "bizarre outfit" and that "[t]hey wanted me to do some unsafe things." (Tr. 15). On this record, we do not find that claimant has established that he is not working due to his compensable back injury.

In the alternative, claimant argues that he is entitled to an adaptability factor of 2.5 pursuant to former OAR 436-35-310(3). We agree. 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 heavy work. (Ex. 19-2, Tr. 14). Claimant's modified work required a light/medium physical capacity. (Tr. 16). Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

Impairment

The Referee found that claimant sustained 11 percent impairment in his low back due to loss of range of motion (2 percent), an unoperated disc (4 percent), and a chronic condition limiting repetitive use of his low back (5 percent). On review, claimant argues that he has additional impairment in the form of a chronic condition that limits repetitive use of his left hip. The insurer argues that claimant has no impairment due to his injury.

Left Hip - Chronic Condition Limiting Repetitive Use

Claimant contends that his testimony and the left hip findings documented in the histories taken by the treating and examining physicians establish that he has a chronic condition limiting repetitive use of his left hip. We disagree.

The applicable standards define "impairment" as a decrease in the function of a body part or system, as measured by a physician. Former OAR 436-35-005(1) [Emphasis supplied]. Former OAR 436-35-320(4) provides for a five percent disability award for chronic conditions which limit repetitive use of an unscheduled body part. Although several physicians note left hip symptoms in their histories of claimant's complaints, none diagnose a chronic condition which limits repetitive use of his left hip. Claimant's testimony is not sufficient to establish this loss under the standards. On this record, we find that claimant has not established that he has a chronic condition limiting repetitive use of his left hip as defined by the "standards." See William K. Nesvold, 43 Van Natta 2767 (1991); Bonnie S. Burke, 43 Van Natta 2466 (1991); Ovid D. Brown, 42 Van Natta 2767 (1990); Martha L. Brunner, 42 Van Natta 2587 (1990).

Loss of Range of Motion

The insurer argues that the range of motion findings reported by Dr. Forgey, treating chiropractor, on July 27, 1990 establish that claimant has no loss of range of motion. (Ex. 20A). However, we determine permanent disability

on the date of the hearing. The range of motion measurements closest to hearing are those taken by the Orthopaedic Consultants on October 31, 1990. (Ex. 22-4). These findings, which we find persuasive, show 1.5 percent loss of flexion and .5 percent loss of extension for a total loss of range of motion of 2 percent.

Low Back - Chronic Condition Limiting Repetitive Use

The insurer argues that the reports of the Orthopaedic Consultants and Dr. Duncan, examining chiropractor, establish that claimant has no chronic condition limiting the repetitive use of his back. We disagree. Both Drs. Forgey and Bell, attending neurologist, diagnose a chronic low back condition and limit claimant's repetitive use of his back as a result of this condition. (Exs. 20A, 24-3).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). There are no reasons not to defer to the opinions of Drs. Forgey and Bell. Thus, claimant is entitled to an impairment value of 5 percent for this condition. Former OAR 436-35-320(4).

Disc Bulge

The insurer argues that claimant's disc bulge at L1-2 is related to degenerative disc disease rather than the work injury. The only evidence of degenerative disc disease is Dr. Forgey's notation "degenerative L5 disc" made as a result of x-rays taken on July 18, 1989. (Ex. 2). Although Dr. Duncan relied on that notation to conclude that claimant "has pre-existing degenerative disc disease at L5-S1," he examined no radiographs himself. (Ex. 12-3).

On the other hand, the Orthopaedic Consultants examined the July 18, 1989 x-rays and found them to be dark with poor detail but showing what appeared to be slight narrowing at the lumbosacral disc level. (Ex. 7-4). However, x-rays taken by the Consultants on October 30, 1989, were considered normal and showed no degenerative changes. (Exs. 7-4, 22-5, 23-1). Furthermore, a March 10, 1990 MRI, a more detailed test than an x-ray, showed no degenerative changes although it showed a disc protrusion at L1-2. (Ex. 14). We do not find that this record establishes that claimant had a preexisting disc disease.

In support of its argument that the disc bulge is not related to the work injury, the insurer relies on: (1) the Consultants' October 30, 1989 opinion that claimant had no neurological or orthopedic abnormality; and (2) Dr. Duncan's opinion that claimant had preexisting degenerative disc disease at L5-S1 but no evidence of radiculopathy. (Exs. 7-4, 12-3). However, the Consultants' opinion was rendered before the MRI. Furthermore, as noted above, we do not find Dr. Duncan's opinion on this subject persuasive.

Dr. Forgey opined that the disc bulge was the result of the work injury. (Ex. 20A). Dr. Bell opined that the L1-2 disc protrusion may substantiate claimant's injury. (Ex. 24-4). Although Dr. Bell's opinion of a possible connection is not sufficient to establish the necessary relationship, it does support Dr. Forgey's opinion. Thus, based on Dr. Forgey's opinion, we find that claimant has established that the disc bulge at L1-2 was caused by the work injury. He is entitled to an impairment value of 4 percent for this condition. Former OAR 436-35-350(2).

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 3, the sum is 3. When that value is multiplied by claimant's adaptability value 2.5, the product is 7.5. When that value is added to claimant's impairment value 11, the result is 18.5 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, 19 percent.

Attorney Fees

Claimant's counsel is entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review for prevailing on the insurer's contention that claimant's permanent disability award should be reduced. See ORS 656.382(2); James H. Wiley, 43 Van Natta 153 (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 attorney's services on review concerning the extent of unscheduled permanent disability is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's reply brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 1, 1991, as reconsidered on March 29, 1991, is modified. In addition to the 14 percent (44.8 degrees) awarded by the Referee, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving him a total award of 19 percent (60.8 degrees) unscheduled permanent disability for a lumbar spine injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. For services on review, concerning the insurer's request for reduction of claimant's award, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer.

In the Matter of the Compensation of
DANI R. CAVE, Claimant
WCB Case No. 90-17756
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The noncomplying employer requests review of Referee Tenenbaum's order that set aside the SAIF Corporation's denial, on its behalf, of claimant's claim for a back injury. In addition, it requests that the matter be remanded on the basis that it was not represented by counsel at the initial hearing. On review, the issues are remand and compensability. We affirm.

FINDINGS OF FACT

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

In September 1990, claimant requested a hearing in this matter. On November 2, 1990, SAIF's counsel wrote the noncomplying employer stating, among other things, "You may wish to consult an attorney to represent you at the hearing. As noted above, I represent SAIF Corporation; I am not your attorney." (Emphasis

in original). The hearing in this matter was convened on January 14, 1991. At that time, the noncomplying employer moved for a postponement on the basis that it was not represented by counsel. The Referee denied the motion. However, she left the record open in order for the noncomplying employer to submit any rebuttal medical evidence that it wished; depose Drs. Tesar and Mizrahi; and present testimony of two witnesses who were not at the January 14, 1991 hearing. A representative for the noncomplying employer was allowed to examine the witnesses at the January 14, 1991 hearing.

The hearing was reconvened on March 11, 1991. At this time, the noncomplying employer was represented by counsel. There was no objection by the noncomplying employer with regard to the January 14, 1991 initial hearing. Although the noncomplying employer did not submit any further medical evidence, it did present testimony of witnesses who were not at the January 14, 1991 hearing.

CONCLUSIONS OF LAW AND OPINION

Remand

The noncomplying employer contends that this matter should be remanded on the basis that it did not have counsel at the January 14, 1991 initial hearing. We decline to remand.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Here, the noncomplying employer contends that the Referee abused her discretion by refusing to postpone the hearing to enable it to retain legal counsel, because the noncomplying employer reasonably believed that it would be represented by SAIF at the hearing.. However, the noncomplying employer had been specifically informed that SAIF did not represent it approximately two months prior the hearing. Accordingly, we agree with the Referee that this was not sufficient basis for postponing the hearing. See OAR 438-06-081.

Further, assuming arguendo that the noncomplying employer was prejudiced by lack of counsel at the initial hearing, the Referee cured any prejudice by continuing the hearing to allow the noncomplying employer to submit any rebuttal medical evidence as well as present further testimony and cross examine claimant's medical expert witnesses. Moreover, the noncomplying employer did obtain counsel for the second hearing and there was no objection at that time to lack of counsel at the initial hearing.

Under these circumstances, we conclude that remand is not appropriate in this instance. Accordingly, we turn to the merits of the case.

Compensability

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

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the noncomplying employer's request for review. 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 attorney's services on review is $1,750, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time

devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated April 3, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,750, payable by the SAIF Corporation on behalf on the noncomplying employer.

January 29, 1992 Cite as 44 Van Natta 132 (1992)

In the Matter of the Compensation of
DAVID R. ABBOTT, Claimant
WCB Case Nos. 87-13097, 87-13096 & 87-13095
ORDER ON REMAND
Vick & Gutzler, Claimant Attorneys
Roy Miller (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. SAIF v. Abbott, 107 Or App 53 (1991). The court initially affirmed that portion of our order that had affirmed and adopted a Referee's order which set aside SAIF's denials of claimant's neck, back, and bilateral arm conditions as invalid under Bauman v. SAIF, 295 Or 788 (1983), and upheld Liberty Northwest's denial. The court also reversed that portion of our order concerning calculation of claimant's disability benefits. 103 Or App 49 (1990). The court then allowed SAIF's motion for reconsideration and remanded for reconsideration of the scope of SAIF's acceptance of the claim. 107 Or App at 53.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On December 15, 1986, SAIF accepted the claim for the following conditions: "right wrist strain" and "right shoulder strain." (Ex. 10).

CONCLUSIONS OF LAW AND OPINION

Our prior order affirmed and adopted the Referee's order which set aside SAIF's denials on the basis that they were not valid under Bauman v. SAIF, supra. Our order also stated, however, that if SAIF's denials were permissible, SAIF and Liberty Northwest would jointly bear responsibility for the claim under Dallas H. Greenslitt, 40 Van Natta 1038 (1988).

The Court of Appeals, in its first decision, also found that SAIF's denials were not valid and that SAIF was responsible for claimant's carpal tunnel syndrome because, under Georgia-Pacific v. Piwowar, 305 Or 494 (1988), SAIF's acceptance of claimant's symptoms encompassed the disease causing those symptoms. SAIF v. Abbott, supra, 103 Or App at 52-54. The court reversed with respect to the basis for temporary total disability benefits, however, finding that, whether or not the case was one of dual employment, SAIF only was responsible for a portion of such benefits "based on the wages [Olympic] paid to claimant." Id. at 54.

The court then allowed SAIF's motion for reconsideration, holding that, if SAIF's allegations were true that its acceptance was specifically for "right wrist strain" and "right shoulder strain," its responsibility would be limited

to those medical conditions. SAIF v. Abbot, supra, 107 Or App at 55-56. The court further found, however, that the exhibits forwarded to the Board and the Court of Appeals were not the ones admitted by the Referee. The court therefore remanded to the Board for reconsideration of the scope of SAIF's acceptance. Id.

The Board then issued an interim order on remand directing the Referee to convene a proceeding to determine the identity of the exhibits which were admitted into evidence at the prior hearing. David R. Abbott, 43 Van Natta 1441 (1991). The order also instructed the Referee to forward the record to the Board, along with an interim order discussing the effect of the inclusion of the correct exhibits. Id. The Referee complied with that order, including the admitted exhibits into the record and finding that SAIF was not precluded from denying claimant's carpal tunnel syndrome because it limited its acceptance to a right wrist and right shoulder strain. We now proceed with our reconsideration.

Under Georgia-Pacific Corp. v. Piwowar, a carrier's acceptance of a claim for a condition includes acceptance of the compensability of the disease causing that condition. 305 Or at 501. This rule does not apply, however, for conditions that are separate from those specified in the notice of acceptance. Id. In this case, SAIF's acceptance was limited to "right wrist strain" and "right shoulder strain." (Ex. 10). There is no medical evidence that claimant's wrist strain was a symptom of his carpal tunnel syndrome. The carpal tunnel syndrome therefore was not within the scope of SAIF's acceptance and SAIF was not required to prove fraud, misrepresentation or other illegal activity in order to justify its denial of the claim.

We therefore address whether SAIF properly denied the claim for lack of responsibility. This case is very similar to the facts in Dallas H. Greenslitt, supra. The claimant in Greenslitt was working in a grocery warehouse while acting as an undercover investigator of suspected drug activities in the warehouse. We held that the claimant satisfied the test for "dual employment" as set out in Mission Insurance Co. v. Miller, 73 Or App 159, 163 (1985), because the claimant was under contract with both employers, the claimant was under the separate control of both employers, and the claimant's warehouse functions were separate and distinct from his investigative functions. 40 Van Natta at 1040-41.

As we held in our previous order, Greenslitt is applicable to this case. Claimant accepted wages from Pinkerton (Liberty Northwest's insured) and Olympic (SAIF's insured), performed the regular duties of an Olympic employee as well as those separate functions of an undercover investigator for Pinkerton, and took separate direction from Olympic and Pinkerton. We conclude that claimant was a dual employee.

In cases of dual employment, the employers may be liable separately or jointly, depending on the severability of the claimant's activities at the time of injury. Greenslitt, 40 Van Natta at 1041 (citing Larson, Workmen's Compensation Law, 48.50 (1986)). As we held in Greenslitt, we find that Pinkerton and Olympic are jointly responsible. Claimant's activities were not severable because, as part of his investigative functions, he was expected to make observations while performing his mill work.

As the Court of Appeals noted in its first decision, when a claimant is working for two employers, benefits generally are measured by the wages from both jobs, but each employer bears its proportionate share of the burden of paying benefits. SAIF v. Abbott, supra, 103 Or App at 54. Because we find that the employers are jointly responsible, SAIF and Liberty Northwest will share in paying claimant's compensation, each amount apportioned based on the wages paid to claimant.

Accordingly, on reconsideration, the Referee's order dated December 31, 1987 is reversed in part and affirmed in part. That portion of the order setting aside SAIF's denials for claimant's occupational disease claim on the basis that they were invalid under Bauman v. SAIF, is reversed. Those portions of the order finding that SAIF is solely responsible for claimant's claim and upholding Liberty Northwest's denial are reversed. Liberty Northwest's denial is set aside. SAIF and Liberty Northwest are jointly responsible for the processing of claimant's claim and will bear a proportionate share of paying claimant's compensation. The remainder of the order is affirmed.

January 29, 1992 Cite as 44 Van Natta 134 (1992)

In the Matter of the Compensation of
BRUCE A. CONKLIN, Claimant
WCB Case No. 90-19855
ORDER ON REVIEW
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Westerband, Moller and Gunn.

Claimant, pro se, requests review of Referee Podnar's order which: (1) declined to award claimant temporary total disability between August 13, 1990 and November 15, 1990; and (2) declined to assess penalties and related attorney fees for allegedly unreasonable claims processing. On review, the issues are temporary total disability benefits, penalties, and attorney fees.

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

The Referee concluded that claimant was terminated for reasons unrelated to his compensable injury. We do not go so far. We conclude that the preponderance of the evidence establishes that claimant was not terminated because of any inability to work due to his compensable injury. On the contrary, claimant was able to work and was working with full pay at the time of his termination. We agree with the Referee that the employer's concerns about claims costs may have been an important factor in the employer's decision to terminate claimant. Such conduct, if true, may give rise to a discrimination claim under ORS 659.410. It would not, however, entitle claimant to temporary total disability benefits after his termination.

ORDER

The Referee's order dated March 15, 1991 is affirmed.

Board Member Gunn dissenting.

The majority correctly concludes this individual was terminated for reasons connected with the filing of a claim, but not any inability to work. Such a finding implies termination was a violation of law and outside "normal employment standards." I believe such a finding should return claimant to an entitlement of temporary total disability, until medically stationary.

The record presents a prima facie case of discrimination pursuant to ORS 659.410 which reads:

> "(1) It is unlawful employment practice for an employer to discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS 656.001 to 656.794 and 656.802 to 656.807, or of 659.400 to 659.460 or has given testimony under the provisions of such sections."

The employer alleges claimant was terminated for four reasons.

(1) Violation of the employees' Saw Blade Policy.

Claimant allegedly failed to properly report or record broken saw blades. Claimant was allegedly aware of the appropriate policy and procedures and failed to follow those policies and procedures. The perplexing thing is that claimant's immediate supervisor testified that the policy did not exist or arise until after claimant's discharge.

(2) Failure to report to work for a Saturday overtime opportunity.

Claimant allegedly signed up to work overtime on a Saturday. The sign up sheet was never produced but in the record is a document from the employer alleging such a sign up document existed and was signed by claimant. Again, this is contrary to the testimony of claimant's immediate supervisor who testified that he knew claimant may be unavailable to work on that date due to a family reunion. The immediate supervisor also testified that he was the person responsible for signing up employees and scheduling overtime work.

(3) Inability of employer to obtain insurance for claimant due to his driving record.

There was a post discharge document in the record which supports the allegation that the employer's insurer would not extend coverage to claimant due to his poor driving record. This is most odd for two reasons. First, at the time of the insurance withdrawal, the employee was not expected to drive due to his injury. Second, most often, insurance companies may raise the employer's overall premiums for employees with poor driving records, not exclude specific employees by name.

(4) Employee's absenteeism and tardiness.

The employer's strongest argument was claimant's record of numerous absences from work and tardy attendance. However, the employer's witness indicated that the critical factor was that employees had to notify the employer in cases of absence or tardiness. In all cases but two, claimant did notify the employer. One instance, the employee did not return from a doctor's appointment related to his injury. The other instance, the alleged Saturday absence mentioned earlier.

Both the employer's representative, immediate supervisor and the employer's personnel file give testimony to the employer's progressive discipline/notice approach to correct employee deficiencies. Yet, no where in the record is this applied to any of the deficiencies cited by the employer as reasons for claimant's discharge. Given the extensive documented absences and tardiness, there should have been some notice in the file advising claimant that such conduct was inappropriate. Documents in claimant's file as to other deficiencies existed, none of which were relied upon by the employer as reasons for discharge.

The record leaves me with the appearance that the employer contrived reasons for claimant's discharge. The evidence in the record that loss of workers' compensation premium rebates were a cause of claimant's discharge are as likely a reason for the discharge as those put forth by the employer.

At this point, under the majority's reading of Safeway Stores v. Owsley, 91 Or App 475 (1988) and Roy H. Robertson, 42 Van Natta 2810 (1990) whether or not employment was terminated outside "normal employment standards," claimant

would still have no entitlement to temporary partial disability and since claimant was working, he loses any entitlement to temporary total disability payments. Since his return to work, his wages equaled or exceeded any amount pursuant to ORS 656.212, he gets nothing. I would distinguish the instant case from Owsley, supra and Robertson, supra, in two areas.

In those two cases, the termination(s) of the claimant(s) was found to have no relationship to the injury or the claim before the Court and Board.

In both of the above-mentioned cases, the claimant had received entitlement to or actual partial disability payments. in this case, it is more likely than not claimant was discharged for reasons related to his filing of a claim and the resultant loss of premium rebates. Also, claimant had never received or been entitled to temporary total or partial disability payments.

Claimant was brought back to work by the employer to avoid payment of temporary total disability payments. Termination of that employment for reasons not founded in "normal employment standards" should return claimant to the previous level of temporary total disability entitlement.

The Court's holding in Owsley as to entitlement to temporary partial disability is a question not to be asked or answered by us or the Court. It would seem absurd to adopt a reading that benefits under ORS 656.210 or 656.212 could be abolished by an offer of return to work followed by a termination of that employment for reasons outside "normal employment standards" or a violation of ORS 659.410. Such a holding would be contrary to ORS 656.012(2)(a):

> "(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents."

Sadly, this case before us is pro se. This is a complicated legal matter with potential causes and actions in other legal venues. I only hope that claimant can retain counsel to properly represent him in all these matters.

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
ORDER ON REVIEW (REMANDING)
Craine & Love, Claimant Attorneys
Pamela Schultz, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Knapp's order which awarded claimant 34 percent (51 degrees) scheduled permanent disability for a right forearm condition, whereas the Notice of Closure had awarded no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We vacate and remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

The Referee relied in part on the findings of Dr. Nathan, the consulting hand surgeon, in rating claimant's scheduled disability. On review, claimant relies on amended ORS 656.245(3)(b)(B) to argue that only her attending physician at the time of claim closure may rate her permanent disability.

ORS 656.245(3)(b)(B) provides, in pertinent part, that "[e]xcept as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." Claimant argues that the reference to an exception to the attending physician rule in ORS 656.245(3)(b)(B) refers to the provision for a medical arbiter in ORS 656.268(7).

Claimant argues that since she did not become medically stationary until April 18, 1990 the provisions of ORS 656.245(3)(b)(B) apply to her case, but the provisions of ORS 656.268(7) do not. We agree. See Or Laws 1990 (Special Session), chapter 2, 54(3).

Thus, the clear language of amended ORS 656.245(3)(b)(B) as applied to the present case means that, although the disability is rated at the time of hearing, only the attending physician at the time of claim closure can provide the findings regarding the worker's impairment. See Dennis E. Connor, 43 Van Natta 2799 (1991).

The pertinent portion of ORS 656.005(12)(a)(A) defines an attending physician as "A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or a board certified oral surgeon licensed by the Oregon Board of Dentistry."

The insurer argues that the record does not indicate whether Dr. Johnson, who practices medicine in Washington, is licensed by the Board of Medical Examiners for the State of Oregon as required by ORS 656.005(12)(a)(A). Claimant replies that remand is the appropriate course in this case because the record is incompletely developed.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Here, the record does not indicate whether Dr. Johnson is licensed as a physician in Oregon, so that he may qualify as claimant's attending physician. Under such circumstances, we cannot determine whether we must, as claimant contends, use Dr. Johnson's impairment findings to rate claimant's permanent impairment. We, therefore, conclude that the record before us has been incompletely and insufficiently developed.

Accordingly, the Referee's order dated March 11, 1991 is vacated. This case shall be remanded to the Presiding Referee to assign a referee to open the record for additional evidence regarding whether Dr. Johnson is licensed as a physician in the State of Oregon and thus qualifies as claimant's attending physician. The assigned referee is instructed to proceed in any manner that will achieve substantial justice. The assigned referee will then issue a final appealable order after reconsidering the issues raised at hearing in light of this order.

ORDER

The Referee's order dated March 11, 1991 is vacated. This matter is remanded to Presiding Referee Emerson for further proceedings consistent with this order.

In the Matter of the Compensation of
RICHARD L. LEATHERS, Claimant
WCB Case No. 90-05998
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Bethlahmy's order which: (1) upheld the insurer's denial of claimant's occupational disease claim for hearing loss; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following modification. Claimant's hearing loss has required diagnostic medical services.

CONCLUSION OF LAW AND OPINION

Hearing Loss

In upholding the insurer's denial of claimant's occupational disease claim for hearing loss, the Referee applied former ORS 656.802(1)(a). Subsequent to the Referee's order, the court has held that an occupational disease claim for hearing loss is properly analyzed pursuant to former ORS 656.802(1)(c). Roseburg Forest Products v. McSperitt, 108 Or App 288 (1991), on remand Larry McSperitt, 44 Van Natta 117 (1992), on recon 44 Van Natta 118 (1992). Consequently, claimant must prove that his exposure to noise at work was the major contributing cause of his hearing loss.

Assuming, without deciding, that claimant's hearing loss required medical services or resulted in disability, claimant has not proven that his work was the major cause of his condition.

Two medical experts have offered opinions concerning the cause of claimant's hearing loss: Dr. Milligan and Dr. Maurer. Neither expert is a treating physician. We rely on the expert reasoned opinion. Somers v. SAIF, 77 Or App 259 (1986).

On November 1, 1989, Dr. Milligan, ear, nose and throat physician, examined claimant and reported that claimant:

> "has high frequency neurosensory loss of recent onset. Works in noise environment but states he wears ear muffs. Noise exposure is the only evident cause of this loss in this patient's history." (Emphasis in original) (Ex. 6).

Assuming that Dr. Milligan was attributing claimant's hearing loss to his work activities, he has not adequately explained his finding, in light of claimant's history of wearing noise protection. Nor has he ruled out other noise-related causes possibly contributing to claimant's loss, including claimant's periodic hunting activities.

Dr. Maurer, clinical audiologist, opined that claimant's work exposure was not the major cause of his hearing loss because the wearing of ear protection would prevent hearing loss associated with noise exposure. (Tr. 74, 75). Dr. Maurer also outlined several other possible causes of claimant's test results

showing hearing loss: (1) the use of firearms; (2) metabolic problems; (3) vascularity/blood pressure problems; (4) earwax; (5) noise intrusion during hearing test; and (6) noise exposure within a hour of the hearing test. (Tr. 66, 71, 73).

Dr. Maurer is a specialist in the field of audiology. (Tr. 56, 57). Further, Dr. Maurer reviewed all the exhibits in the present case, reviewed Dr. Milligan's report and examined claimant and a co-worker who is exposed to the same work conditions. (Tr. 58). Under such circumstances, we defer to the well-reasoned opinion of Dr. Maurer. Somers v. SAIF, supra.

Accordingly, we conclude that claimant has failed to establish a compensable hearing loss claim. Therefore, we find that the Referee properly upheld the insurer's denial of claimant's hearing loss claim.

Penalties and Attorney Fees

We adopt the Referee's Conclusions of Law and Opinion on this matter.

ORDER

The Referee's order dated March 6, 1991 is affirmed.

In the Matter of the Compensation of
PATSY B. MARTY, Claimant
WCB Case Nos. 90-19475 & 90-19474
ORDER ON REVIEW (REMANDING)
Black, et al., Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Scott Wetzel Services requests review of Arbitrator Brown's order that: (1) set aside its denial of claimant's aggravation claim for a low back injury; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We remand.

FINDINGS OF FACT

The Board adopts the Arbitrator's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We review the Arbitrator's order solely on questions of law. ORS 656.307(2). Where an arbitrator's order is not consistent with applicable law, we remand for the proper application of law. See Concetta M. Crowder, 43 Van Natta 1741 (1991).

Here, the Arbitrator concluded that, because claimant's injury with the second insurer (SAIF) had occurred to the same body part as her injury with the first insurer (Scott Wetzel), the new injury had combined with the old. Consequently, the Arbitrator concluded that, under ORS 656.005(7)(a)(B), the resultant condition was compensable only to the extent that it was the major contributing cause of the disability or need for treatment. Because he found that the evidence indicated that only 50 percent of claimant's condition was attributable

to the second injury, the Arbitrator left responsibility with Scott Wetzel, the first insurer.

Subsequent to the Arbitrator's order, we issued our opinion in Rosalie S. Drews, 44 Van Natta 36 (1992). In Drews, we concluded that ORS 656.005(7)(a)(B) is not applicable in a responsibility context for purposes of assigning responsibility. Moreover, in order to carry its burden of proof and shift responsibility to a subsequent insurer, we concluded that the first insurer with an accepted claim was required to prove only that the subsequent injury materially contributed to claimant's condition. Drews, supra.

Accordingly, because the Arbitrator applied ORS 656.005(7)(a)(B) and the "major contributing cause" standard in this case, we find that this matter was not analyzed under the applicable law. Because we review only questions of law, we must remand for additional findings, and a determination of which carrier is responsible when the correct rule of law is applied. See ORS 656.307(2); Concetta M. Crowder, supra.

ORDER

The Arbitrator's order dated February 28, 1991 is vacated. This matter is remanded to Arbitrator Brown for a determination of the responsible carrier. Arbitrator Brown may make that determination with or without further proceedings in any manner which achieves substantial justice.

In the Matter of the Compensation of
RAYMOND D. MCKEE, Claimant
WCB Case No. 90-05999
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Bethlahmy's order which: (1) upheld the insurer's denial of claimant's occupational disease claim for hearing loss; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following modification. Claimant's hearing loss has required diagnostic medical services.

CONCLUSION OF LAW AND OPINION

Hearing Loss

In upholding the insurer's denial of claimant's occupational disease claim for hearing loss, the Referee applied former ORS 656.802(1)(a). Subsequent to the Referee's order, the court has held that an occupational disease claim for hearing loss is properly analyzed pursuant to former ORS 656.802(1)(c). Roseburg Forest Products v. McSperitt, 108 Or App 288 (1991), on remand Larry McSperitt, 43 Van Natta 117 (1992) on recon, 43 Van Natta 118 (1992). Consequently, claimant must prove that his exposure to noise at work was the major contributing cause of his hearing loss.

Assuming, without deciding that claimant's hearing loss required medical services or resulted in disability, claimant has not proven that his work was the major cause of his condition.

On December 11, 1989, Dr. Milligan, ear, nose and throat physician, examined claimant and reported that claimant:

> ". . states that he works in a very noisy environment though he denies working without hearing protection. He has no family history of hearing loss and no history of injuries to either ears in the past." (Ex. 8).

Dr. Milligan further noted:

> "My only concern in regarding this patient's audiologic evaluation is that he does, in fact, show some slow progression of hearing loss, particularly in the right ear over several years period. However, in review of his audiologic studies from [his employer], he actually has varied as much as 10-15 db. in his studies at [his employer] from the past. He would alternate from poor hearing one year and actually improve the next. In consideration of the legal implications of his hearing level at this time, it would probably be advisable that [claimant] be reevaluated audiologically. I think it would be important that he realize the importance of a forthright and honest response to that audiologic study as the present levels are not consistent with the natural history of a slowly progressive noise induced hearing loss." (Ex. 8).

In light of Dr. Milligan's concerns regarding the consistency of claimant's audiologic testimony, we do not consider Milligan's opinion to be sufficient to satisfy claimant's burden of proof.

Dr. Lindgren, an otolaryngology specialist, examined claimant on July 10, 1990 and reported that he had no knowledge of the intensity of claimant's job-related noise exposure. (Ex. 13). Dr. Lindgren based his opinion only on claimant's accounting of his work environment. Dr. Lindgren did not review claimant's prior audiological studies. Dr. Lindgren then found that claimant's job activities were the major cause of his hearing loss.

We are not persuaded by Dr. Lindgren's opinion. He does not explain the reasoning behind his analysis. Consequently, we find Dr. Lindgren's report to be conclusory and not well-reasoned or persuasive. Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceilings Systems, 44 Or App 429, 433 (1980).

Dr. Maurer, professor of Speech and Hearing Sciences at Portland State University, is a specialist in the field of audiology. (Tr. 56, 57). Dr. Maurer reviewed all the exhibits in the present case, reviewed the reports of Dr. Milligan and Dr. Lindgren and examined claimant and a co-worker who is exposed to the same work conditions. (Tr.58).

Dr. Maurer opined that claimant's work exposure was not the major cause of his hearing loss because the wearing of ear protection would prevent hearing loss associated with noise exposure. (Tr. 74, 75). Dr. Maurer also outlined several other possible causes of claimant's test result showing a hearing loss: (1) the use of a tractor; (2) metabolic problems; (3) vascularity/blood pressure problems; (4) earwax; (5) noise intrusion during hearing test; and (6) noise exposure within a hour of the hearing test. (Tr. 66, 71, 73).

We defer to the well-reasoned opinion of Dr. Maurer who did not find that claimant's employment conditions were the major cause of his hearing loss. Somers v. SAIF, supra.

Accordingly, we conclude that claimant has failed to establish a compensable hearing loss claim. Therefore, we find that the Referee properly upheld the insurer's denial of claimant's hearing loss claim.

Penalties and Attorney Fees

We adopt the Referee's Conclusions of Law and Opinion on this matter.

ORDER

The Referee's order dated March 6, 1991 is affirmed.

January 29, 1992 Cite as 44 Van Natta 142 (1992)

In the Matter of the Compensation of
GERRY J. ODE, Claimant
WCB Case No. 91-00084
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Lipton's order which: (1) found that claimant was an Oregon subject worker temporarily working out of state; and (2) set aside SAIF's denial of claimant's injury claim. On review, SAIF contends that claimant's injury did not arise out of the course and scope of his employment. We affirm.

FINDINGS OF FACTS

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

CONCLUSIONS OF OPINION AND LAW

The Referee concluded that at the time of his injury, claimant was an Oregon worker temporarily working out of state employed by an Oregon company, SAIF's insured. We agree.

In order to be compensable, claimant's injury must have occurred in the course and scope of his employment. ORS 656.005(7)(a). The ultimate inquiry is whether the relationship between the injury and employment is such that the injury should be compensable. Rogers v. SAIF, 289 Or 633 (1985); Mellis v. McEwen, 74 Or App 571, 575 rev den 300 Or 249 (1985).

In our de novo review, we rely on the seven factors first identified by the Court of Appeals in Jordan v. Western Electric Co., 1 Or App 441 (1970) in determining whether an injury is work-related: (1) whether claimant's activity at the time of the injury was for the benefit of the employer; (2) whether the activity was contemplated by the employer and the employee; (3) whether the activity was an ordinary risk of, and incidental to, the particular employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed or acquiesced in by the employer; and (7) whether the employee was on a personal mission. Timberline Lodge v. Kyle, 97 Or App 239 (1989); Preston v. SAIF, 88 Or App 327 (1987); Mellis v. McEwen, Hanna, Grisvold, supra. All of these factors are considered and no one factor is dispositive. Id.

Benefit to the Employer

Claimant's injury occurred while he and his foreman were performing extra-work beyond the original construction contract of their job. The construction project, which was conducted out-of-state, could not have been commenced until the extra-work was first completed. (Tr. 27). The employer paid his employees a $15.00 per day subsistence pay plus other out-of-state expenses. (Ex. 8). Had the extra-work not been done by the employer's employees, they would have had to "sit and wait" until it was completed. (Tr. 32).

Under these circumstances, we conclude that it was to the employer's benefit to have his own employees do the extra-work. In addition, whether the other company directly paid the employees or whether it paid the employer and he then paid the employees, as was the usual custom, the extra-work would not have been a cost to the employer. Instead, completing the job without further delays would have represented a benefit to the employer by avoiding "downtime."

The foreman did not get a change order, as is the company's policy before extra-work is engaged in by the employer's employees. (Tr. 30). However, the employer explained that a change order is his first preference, with his second preference being "an oral agreement or somebody being responsible for payment." (Tr. 44). Moreover, the employer believed that the foreman did the right thing by getting the job done. (Tr. 38).

Activity Contemplated by the Employer

The employer had previously negotiated change orders and allowed extra-work beyond the original construction contract to be done by his employees. (Tr. 35). Prior to his injury, claimant had, in fact, engaged in such extra-work arrangements while working for this employer. (Tr. 10, 11). Consequently, we conclude that claimant's activity when he was injured was contemplated by the employer.

Ordinary Risk of and Incidental to Employment

The employer's construction contracts were for installing racquetball courts. Approximately every one in six-to-ten jobs involved extra-contractual work. (Tr. 8). All of the employees knew how to do the work and the employer would authorize his employees to perform the work. (Tr. 33). Further, many times the developers did not have their own carpenters to do the job and it was necessary to have the employer's employees perform the extra-work to complete the installation of the racquetball courts. (Tr. 34). Therefore, we find that the activity claimant was performing at the time of his injury was an ordinary risk of and incidental to his employment.

Payment for the Activity

When claimant worked out-of-town, in addition to his regular hourly pay, he was paid a $15.00 per day subsistence pay. Other "away" expenses were also paid. (Ex. 8). Although we are unable to determine whether claimant was paid for the one hour of extra-work he completed before his injury, we find that he was on paid time for his employer. We reach this conclusion regardless of whether the other company first paid the employer and the employer then paid the employee or if the other company involved had planned to render payment directly to claimant.

Activity on Premises

Although the activity did not occur on premises owned by the employer, it is the nature of the employer's business that work activities be conducted on the premises of others. Furthermore, until the extra-work was completed,

claimant was required to stay in the area until he could begin the contracted work. (Tr. 32).

Employer Direction and Acquiescence

At the time of the injury, claimant was under the direction of the foreman for that particular job. (Tr. 5, 35). This job was the first time this foreman had to make a decision without assistance from the employer. (Tr. 37). The company policy was that there was to be a "change order" before extra-work was do be done. (Tr. 30). This foreman did not get a change order, but instead instructed claimant that they were going to do it and get paid in cash. (Tr. 7). The foreman had the authority to direct claimant. (Tr. 35-38). Claimant believed the foreman had cleared this with the employer. (Id). Further, the employer believed that the foreman did the right thing by getting the job done. (Tr. 38). Consequently, we conclude that the employer, through his foreman, either directed or acquiesced in the activity which claimant was performing when he sustained his injury.

Personal Mission

Because we find that the extra-work was for the benefit of the employer, we find that claimant was not on a personal mission. See James D. Reynolds, 43 Van Natta 2602, 2605 1991).

Conclusion

Although no one factor is dispositive, our conclusions concerning each factor, when taken as a whole, persuade us that there is a significant work-connection between claimant's injury on July 16, 1990 and his employment. Accordingly, we agree with the Referee that claimant's injury arose out of the course and scope of his employment.

Inasmuch as SAIF has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. 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 assessed fee for claimant's counsel services on review concerning the compensability issue is $900, to be paid by SAIF.

ORDER

The Referee's order dated April 17, 1991 is affirmed. For services on 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
JOSEPH W. RAMSAY, Claimant
WCB Case No. 90-07488
ORDER ON REVIEW
Gracey & Davidson, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Michael V. Johnson's order which upheld the insurer's denial of claimant's chest injury claim. On review, the issue is compensability.

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

The insurer asserts that claimant's brief should be stricken as untimely filed with the Board. Claimant's brief was due on June 19, 1991. OAR 438-05-046(1)(a) provides that "filing" means the physical delivery or the date of mailing. For documents other than requests for hearing or Board review, filing can be accomplished by first class mail. OAR 438-05-046(1)(c). The rule further provides that an "attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. If the thing is not received within the prescribed time and no certificate of mailing is furnished, it shall be presumed that the filing was untimely unless the filing party establishes that the filing was timely." Id.

Here, claimant contends that the transmittal letter accompanying his brief and bearing the date June 19, 1990 qualifies as a certificate of mailing. We do not agree. The date on a letter may evidence when the letter was written, but it does nothing to certify the date of mailing. However, the envelope containing the brief is postmarked "June 19, 1990." This fact is uncontested. We find that the postmark establishes that filing was timely.

Claimant argues that we should reject the Referee's finding that claimant was not a credible witness and should find that he proved that his claim is compensable. Although it is not statutorily required, we generally defer to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). We do so in this case. Along with the reasons cited by the Referee, we also note that claimant, when he finally told medical personnel that he had been injured at work, did not consistently describe the way he was injured. On his 801 and 827 forms, as well as at hearing, claimant maintained that he first felt chest pain while lifting a couch onto a truck. However, he told his treating physician, Dr. Cummings, that he first felt pain while lifting some boxes at work, Ex. 2-1, and told Dr. Struckman that, while lifting a couch, he fell over and the couch landed on top of him, Ex. 12-1.

Claimant also contends that the Referee, without finding that claimant's wife was not credible, simply ignored her testimony substantiating claimant's allegation that he was injured on February 17. As the court noted in Erck, in some cases a finding that one witness is or is not credible necessarily is a finding that another witness is or is not credible. 311 Or at 527 n. 7. Here, we find that the Referee, by disgarding claimant's version and crediting the testimony of co-employees, implicitly found claimant's wife's testimony to be not credible.

Finally, claimant contends that we should remand this case in order for him to have the opportunity to present the testimony from Addie Potts. Potts owns a farm where claimant sometimes does work. Claimant argues that, with her testimony, he could prove that his injury was not a result of working on the farm.

ORS 656.295(5) provides that "if the board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee, it may remand to the referee for further evidence taking, correction or other necessary action." Here, the Referee explicitly did not find that claimant injured his chest while working on Potts' farm, instead concluding that claimant failed to prove that he was injured while working for the employer. We agree. The record, therefore, is not insufficiently developed and we decline to remand.

ORDER

The Referee's order dated January 17, 1991 is affirmed.

In the Matter of the Compensation of
BETTY J. CURTISS, Claimant
WCB Case No. 90-21077
ORDER ON REVIEW
Richard Nesting, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Thye's order that ordered payment of permanent total disability benefits pursuant to a previous referee's August 31, 1990 Order on Reconsideration. On review, the issue is stay of payment pending appeal. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant requested a hearing on November 15, 1990, contending that the employer had failed to comply with the previous referee's August 31, 1990 Order on Reconsideration and seeking penalties and attorney fees.

CONCLUSIONS OF LAW AND OPINION

Relying on Section 54(2) of Oregon Laws 1990 (Special Session), Referee Thye concluded that the former version of ORS 656.313 was applicable since claimant's hearing request which resulted in the earlier referee's August 9, 1990 order, as reconsidered on August 31, 1990, was filed before May 1, 1990 and the hearing was convened before July 1, 1990. We disagree that either Section 54(2) or former ORS 656.313 is applicable here.

Section 54(2) provides:

> "Any matter regarding a claim which is in litigation before the Hearings Division, the Board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990."

We have recently held, under substantially similar facts, that the issue of whether payment of compensation is stayed pending appeal is not the same "matter regarding a claim" as the substantive question of entitlement which was previously in litigation. Raymond J. Seebach, 43 Van Natta 2687 (1991); Gary R. LaChance, Sr., 43 Van Natta 2746 (1991). Here, the issues presented to Referee Thye did not arise until issuance of the previous referee's August 31, 1990 Order on Reconsideration which addressed the issue of extent of permanent disability. Therefore, the issue of stayed compensation could not have been before the previous referee for the issue arose after he issued his order. Similarly, the question before Referee Thye of whether payment of compensation is stayed pending appeal was separate and distinct from the issue of extent of permanent disability before the previous referee. Claimant's request for hearing on the issue of stayed compensation was not filed until November 15, 1990, and the hearing was not convened until February 8, 1991. Thus, we find that the litigation "savings clause" does not apply. Raymond J. Seebach, supra.

Further, the matter at issue here is not subject to a special exception to the act's general applicability provision. See e.g. Section 54(3). Moreover, neither party contends that application of the 1990 amendments will produce an absurd or unjust result inconsistent with the purposes and policies of the

workers' compensation law. See Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, this case is properly analyzed under the Workers' Compensation Act as amended, effective July 1, 1990.

As amended, ORS 656.313((1)(a)(B) provides that the compensation appealed is stayed except for "[p]ermanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed." Consequently, pending the review process, the employer was entitled to stay payment of permanent total disability compensation through the day before the issuance of the earlier referee's order appealed by the employer. ORS 656.313(1)(a)(B). Here, the employer has paid permanent total disability benefits commencing September 1, 1990. Accordingly, we reverse the Referee's order which held that the employer was obligated to pay claimant's permanent total disability compensation from October 1985.

ORDER

The Referee's order dated March 14, 1991 is reversed.

January 30, 1992 Cite as 44 Van Natta 147 (1992)

In the Matter of the Compensation of
EDWANA L. ECCLESTON, Claimant
WCB Case No. 91-00764
ORDER ON REVIEW
George W. Sohl, Claimant Attorney
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Mongrain's order that: (1) found that claimant had not established "good cause" for her untimely hearing request from the SAIF Corporation's denial of her aggravation claim for a low back condition; and (2) dismissed claimant's hearing request as untimely. On review, the issue is whether claimant established good cause for her untimely request. We affirm.

FINDINGS OF FACT

SAIF mailed its denial of claimant's low back aggravation claim on November 2, 1990 and claimant received it on November 5, 1990. (Tr. 5 and Ex. 116).

Claimant or her attorney misplaced the denial and her attorney told her he could not file a request for a hearing without knowing the original date of the denial. (Tr. 5). Because he was not as yet on retainer, her attorney asked claimant to contact SAIF. (Tr. 5). She received a copy of the denial on January 9, 1991, after contacting the Workers' Compensation Board. (Tr. 6).

Claimant's attorney mailed claimant's request for a hearing on the denial on January 18, 1991 and it was received on January 22, 1991.

FINDINGS OF ULTIMATE FACT

Claimant's hearing request was not filed within 60 days of SAIF's November 5, 1990 denial and she did not have good cause for delay in filing a request.

CONCLUSIONS OF LAW AND OPINION

Claimant has 60 days to request a hearing on a denial, or 180 days if good cause for the failure to request within 60 days is shown. ORS 656.319(1).

The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCO 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. Id.

Here, claimant filed her request for hearing 60 days after notice, but within 180 days. Claimant contends that she has shown good cause for her untimely filing. While she concedes that she received the denial on November 5, 1990, she argues that, after showing it to her attorney, the denial was misplaced and she was unable to get a copy until January 9, 1991.

We do not agree that claimant's alleged inability to obtain a copy of the denial constitutes good cause. A copy of the denial is not needed to file a request for a hearing. A request for a hearing need only state that a hearing is desired. ORS 656.283(3). Moreover, claimant and her attorney had an opportunity to review the denial before it was misplaced, and, if the attorney wanted the specific date of the denial, all that was required was a telephone call. We conclude, based on the circumstances here, that claimant's lack of diligence in this matter does not constitute good cause for untimely request for a hearing. See Maria Guerra, 43 Van Natta 677 (1991). Accordingly, we affirm the Referee's dismissal of claimant's request for a hearing.

ORDER

The Referee's order dated March 19, 1991 is affirmed.

In the Matter of the Compensation of
KENNETH A. FOSTER, Claimant
WCB Case No. 90-11827
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Thye's order that: (1) upheld the SAIF Corporation's denial of his right foot injury claim; and (2) declined to assess penalties and related attorney fees for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant worked as a volunteer firefighter for SAIF's insured, in addition to his full-time employment as a welder. He was paid every three months for his volunteer work.

On March 30, 1990, claimant responded to an emergency call. He rode the rescue van to the scene, went into the victim's house and was walking hurriedly back to the van when he stepped down and felt a sharp pain in his right foot. When he returned to the fire station, his right foot was painful and sore.

Claimant missed his full-time work the next day and went to the hospital emergency room. Dr. Rose, the emergency room physician, diagnosed a fifth metatarsal fracture of the right foot of unknown etiology. (Ex. 3). While

claimant's emergency room x-rays disclosed that the fracture had both chronic and acute processes, he told Dr. Rose that he did not have any previous symptoms. (See Exs. 3 and 4).

Claimant saw Dr. Erkkila, an orthopedist, the following Monday, April 2, 1990. In his April 17, 1990 letter to SAIF, Erkkila stated that claimant's injury was work-related. (Ex. 7-A). In addition, Dr. Erkkila opined in both his September 13, 1990 and October 23, 1990 letters that, while claimant may have had a previous stress lesion in his right foot, the March 30, 1990 incident was the final precipitating event which caused his fracture. (Exs. 10 and 12).

While claimant could not initially pinpoint the specific cause of his injury, he consistently indicated that the onset occurred the evening of March 30, 1990, while working as a volunteer firefighter. (See Exs. 2, 3, 5, 6, 7-A, 7-B, 9, 10 and 12). Moreover, even though claimant first named his full-time employer, he later determined and consistently named SAIF's insured as the responsible employer. (See Exs. 1, 6, 7-A, 7-B, 9 and 12).

On April 3, 1990, claimant submitted an 801 Form, indicating that he was injured while on duty with SAIF's insured and listing treatment by both the hospital emergency room and Dr. Erkkila, who was named as claimant's treating physician. (Ex. 6). SAIF received claimant's 801 Form on April 10, 1990 (Tr. 13), and denied the claim on April 13, 1990, contending that there was insufficient evidence that claimant's fracture was work-related. (Ex. 7).

Before denying claimant's claim, SAIF did not contact claimant for a statement. (Tr. 8). Moreover, even though SAIF conceded at hearing that the compensability of claimant's claim was a medical question, it did not seek a medical opinion from claimant's treating physician, the hospital emergency room or its own in-house medical expert before denying the claim. (See Tr. 21-22 and Exs. 7-A, 7-B and 9).

ULTIMATE FINDINGS OF FACT

Claimant had a preexisting stress lesion on his right foot prior to his compensable injury.

On March 30, 1990, claimant suffered an accidental injury to his right foot, which arose out of and in the course of his work as a volunteer firefighter and was a material contributing cause of his disability or need for medical services. This injury combined with claimant's preexisting stress lesion to cause or prolong his need for treatment. However, the injury remained the major contributing cause of his disability and need for treatment for his resultant condition.

At the time of its denial, SAIF did not have a legitimate doubt concerning its liability for claimant's injury claim.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Oregon Laws 1990, Chapter 2, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Oregon Laws 1990, Chapter 2, Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we

analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Compensability

The Referee concluded that claimant failed to prove that he sustained a compensable injury on March 30, 1990 while working as a volunteer firefighter. We disagree.

Because we find that prior to March 30, 1990 claimant had a preexisting stress lesion in his right foot, this case is governed by amended ORS 656.005(7)(a)(B). Under that provision, we have recently held that, if there is a preexisting condition, whether a claim is compensable is a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, it must be determined whether there was a compensable injury. ORS 656.005(7)(a). Then, if it is determined that there is a preexisting condition and that the condition combined with the injury to cause or prolong disability or need for treatment, claimant is entitled to disability compensation and treatment if the injury was the major contributing cause of the resultant or need for medical treatment. ORS 656.005(7)(a)(B).

There is evidence in the record which we find persuasive, that claimant had a preexisting stress lesion. In light of this medical evidence, we find that the cause of claimant's right foot fracture is a complex medical question and rely on expert medical opinion to resolve the issue. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Here, claimant was first treated at the hospital emergency room by Dr. Rose, the day after the March 30, 1990 incident. Dr. Rose later opined that, because of the presence of both chronic and acute processes in the area of the fracture, claimant's fracture occurred at least one week before claimant reported experiencing pain. Claimant saw Dr. Erkkila, an orthopedist, the following Monday. Erkkila opined that claimant's fracture was work-related. (Ex. 7-A). Erkkila stated that claimant had a preexisting stress lesion in his right foot and that his walking hurriedly to the rescue van the evening of March 30, 1990 was the final event and the major contributing cause of claimant's resulting fracture. (See Exs. 7-A,10, 11 and 12). We find Dr. Erkkila's opinion persuasive because he is claimant's treating physician and, as an orthopedist, he is a specialist in this area. Moreover, his opinion is well-reasoned and explains both claimant's lack of previous symptoms and the chronic and acute processes evident in claimant's emergency room x-rays which lead Dr. Rose to suspect that claimant's fracture occurred at least one week prior to the March 30, 1990.

We find Dr. Erkkila's opinion sufficient to satisfy both prongs of the "Nazari" test. Accordingly, we conclude that claimant's claim is compensable because claimant sustained a compensable injury on March 30, 1990 while working for SAIF's insured and this injury was and remained the major contributing cause of his disability and his current need for medical services.

Penalty and Attorney Fees

While the Referee did not make findings as to this issue, it was raised and litigated at hearing (see Tr. 1 and 13-29) and we, therefore, address it here. In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability. If the insurer based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and

history. Although the Referee's order issued before our order in Robertson, his construction of the statute is consistent with our interpretation. For the reasons stated in the Referee's order, we also find that claimant established his claim with medical evidence supported by objective findings.

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the insurer's request for review. See 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 compensability is $600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 10, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $600, to be paid by the insurer.

In the Matter of the Compensation of
BENNY W. SAMPLES, Claimant
WCB Case Nos. 89-22172, 89-15774, 89-15773 & 89-22171
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Tenenbaum's order that declined to award a carrier-paid attorney fee for services rendered concerning the SAIF Corporation's rescission of its denial and acceptance of claimant's aggravation claim without a hearing. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant's counsel was instrumental in obtaining compensation for claimant's aggravation claim without a hearing.

CONCLUSIONS OF LAW AND OPINION

On November 23, 1990, we remanded this case to the Referee. Benny W. Samples, 42 Van Natta 2642 (1990). At issue was whether claimant was entitled to a carrier-paid attorney fee for his counsel's services in prompting the rescission of SAIF's denial and its acceptance of claimant's aggravation claim. On remand, the Referee found that claimant's attorney did not actively and meaningfully participate in the resolution of the responsibility issue during the six-day period between the date the Board received the order designating a paying agent under ORS 656.307 and the date that SAIF accepted responsibility for claimant's aggravation claim. Consequently, the Referee declined to award a carrier-paid fee, in addition to the out-of-compensation fee that had been previously awarded.

preexisting C4-5 disc disease. Thus, we conclude that claimant has not established a compensable occupational disease.

ORDER

The Referee's order dated October 9, 1990 is affirmed.

February 5, 1992 Cite as 44 Van Natta 197 (1992)

In the Matter of the Compensation of
MANUEL MICHACA, Claimant
WCB Case No. 90-18924
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Pamela Schultz, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee McCullough's order which set aside its denial of claimant's left rib cage area injury. On review, the issue is compensability.

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

The insurer first asserts that claimant failed to prove that his injury arose out of and in the course of his employment. The insurer bases this assertion on its contention that claimant did not provide consistent histories regarding the accident to the employer and his doctors and therefore he is not a credible witness, nor are the reports from his doctors reliable evidence.

We agree with the Referee that claimant's history of the accident, as testified to at the hearing and reported to his doctors are all essentially consistent except for the January 15, 1991 report from Dr. Webb. However, we find that this one inconsistency does not prevent claimant from carrying his burden of proof in view of the Referee's finding that claimant is credible, as well as the fact that Dr. Webb's initial report described the accident consistently with claimant's testimony at hearing, while the January 15 report was written five months after Webb stopped treating claimant.

The insurer next argues that claimant failed to prove his claim with medical evidence supported by objective findings, as required by ORS 656.005(7)(a). In this regard, the Referee's construction of the statute is consistent with our order in Suzanne Robertson, 43 Van Natta 1505 (1991). The insurer asserts, however, that "the decision in Robertson was wrong, and the holding should be overturned in this case."

In Robertson, we construed the "objective findings" requirement in ORS 656.005(7)(a) to be satisfied if a physician examines the worker and, based on that examination, finds that the worker suffers from a disability or a physical condition that requires medical services. This evaluation may be based on the worker's description of the pain that she is experiencing, but the report cannot merely recite the claimant's complaints of pain and must indicate that the claimant does, in fact, experience symptoms. Suzanne Robertson, supra at 1507.

We decline to grant the insurer's request that we disavow Robertson. Unlike its construction of ORS 656.005(7)(a), we based our interpretation of the language of the statute on legislative intent, as evidenced by the legislative

"(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease." (Emphasis added).

The first physician who expressly attributed claimant's current symptoms to work-related C4-5 disc disease was Dr. Rabie in March 1990. (Ex. 69a). We therefore conclude that this was the earliest claimant should have reasonably discovered that his symptoms were potentially attributable to an occupational disease at C4-5. Because claimant filed his occupational disease claim at hearing in July 1990, we find that claimant timely filed his occupational disease claim. See Norman L. Winter, 43 Van Natta 144 (1991). The first evidence in the record of C4-5 disc disease is a 1985 myelogram showing osteophyte formation at C4-5. However, there is no evidence that claimant's doctor informed him of this condition, or attributed his continuing symptoms to this condition, as distinct from claimant's advanced disc disease at other levels of the cervical spine.

We turn to the merits of the claim. For an occupational disease claim, the date of disease is the date upon which claimant was last exposed to employment conditions which allegedly caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last exposure to the work which he alleges caused a worsening of his preexisting degenerative cervical condition was in November 1989. Accordingly, the occupational disease law, which became effective January 1, 1988, is applicable. See Johnson, supra, at 146-48.

Here, claimant's work activities included repetitive twisting and turning of the neck. Considering such circumstances, we conclude this claim is for a condition resulting from a "series of traumatic events or occurrences" pursuant to former ORS 656.802(1)(c).

To establish that his condition is compensable under former ORS 656.802(1)(c), claimant must prove that his work activities were the major contributing cause of a worsening of his underlying condition and that such worsening resulted from a series of traumatic events or occurrences. Former ORS 656.802(1)(c); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991).

When there is a dispute between medical experts, the greater weight will be given to those medical opinions which are both well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

Only Dr. Rabie opines that claimant's C4-5 disc condition was the result of his work activities. (Ex. 69a). However, he examined claimant only once, three days after the December 1988 injury. (Ex. 48A). Thus, he had no direct knowledge of the May 1990 flare up leading up to the C4-5 surgery. Further, although Dr. Rabie was aware that claimant's 1966 surgery did not restore claimant's cervical spine to normal, it is not apparent from Rabie's brief opinion that he considered claimant's history of C4-5 osteophytes and the possible effect of the prior surgeries at C5-6 and C6-7.

Dr. Fuller, orthopedist, examined claimant twice and reviewed all of the exhibits. Fuller found that the major cause of claimant's current condition was the altered cervical mechanics caused by the 1966 diskectomy. (Ex. 78-10 through 78-13, 78-64).

Given the conclusory nature of Dr. Rabie's report and Dr. Fuller's well reasoned, contrary opinion, we conclude that claimant has not proved that his work activities were the major contributing cause of a worsening of his

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following corrections. The examination referred to in paragraph 13 was performed by Dr. Denker on January 13, 1989, not 1990. (Ex. 48C).

A Determination Order issued July 28, 1989, not June 28, 1989 as indicated in paragraph 20. (Ex. 64).

FINDINGS OF ULTIMATE FACT

The May 5, 1989 Stipulated Order adjudicated the issue of whether the December 27, 1988 injury worsened claimant's preexisting degenerative C4-5 disc disease.

Claimant's work activities were not the major contributing cause of a worsening of claimant's C4-5 disc disease.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing before May 1, 1990 and a hearing was convened before July 1, 1990, his claim is properly analyzed under the Workers' Compensation Law in effect prior to the 1990 revisions. See Or Laws 1990 (Special Session), ch.2, 54(2).

Res Judicata and Aggravation

We adopt the Referee's reasoning and conclusion on both claim preclusion and issue preclusion. Because we agree that the May 5, 1989 Stipulated Order precluded claimant from contending that the December 1988 injury worsened his C4-5 disc disease, we do not address the issue of aggravation.

Occupational Disease

The Referee found that claimant did not argue the compensability of his disc disease on an occupational disease theory. We disagree and find that claimant raised this issue at hearing. (Tr. 8). Inasmuch as the insurer did not object to the "prematurity" of proceeding with a hearing on claimant's occupational disease claim, it has waived its opportunity to object to the claim on that basis. Thomas v. SAIF, 64 Or App 193 (1983).

The insurer argues that the occupational disease issue is time barred. It contends that claimant knew in the early 1970's that his degenerative cervical condition was being aggravated by work activities. It further argues that claimant was informed that he had an occupational disease by Dr. Brett's September 1985 report which stated that claimant could not return to jackhammer work because it aggravated his pain. (Ex. 41-10). Because both of these dates were more than one year prior to claimant's occupational disease claim made at hearing, the insurer contends that claimant is time barred pursuant to former ORS 656.807(1).

Former ORS 656.807(1) provides, in pertinent part, that:

> "(1) All occupational disease claims shall be void unless a claim is filed with the insurer . . . by whichever is the later of the following dates:
>
> "(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved. We note that claimant's counsel is not entitled to an attorney fee on review for defending the Referee's award of an assessed attorney fee. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 13, 1991 is reversed in part and affirmed in part. For the insurer's unreasonable claims processing, claimant's counsel is award a penalty-related attorney fee of $1,000, payable by the insurer. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $1,200, payable by the insurer.

February 5, 1992 Cite as 44 Van Natta 194 (1992)

In the Matter of the Compensation of
LANCE M. KITE, Claimant
WCB Case No. 91-00996
ORDER OF DISMISSAL
Malagon, et al., Claimant Attorneys
Snarskis, et al., Defense Attorneys

Claimant requested review of Referee Garaventa's order that dismissed claimant's hearing request concerning his entitlement to palliative care. The parties have entered into a "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in WCB Case No. 91-04247, a case which was pending before the Hearings Division. Pursuant to the settlement, claimant agrees that his request for Board review "shall be dismissed."

The settlement has received Referee approval. In accordance with the approved settlement, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

February 5, 1992 Cite as 44 Van Natta 194 (1992)

In the Matter of the Compensation of
FRANK J. KNAPP, Claimant
WCB Case No. 90-00715
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Tooze, Shenker, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant requests review of those portions of Referee Otto's order that: (1) found that the May 5, 1989 Stipulated Order precluded litigation of claimant's claim for his C4-5 disc disease on the theory his December 1988 injury worsened that condition; (2) upheld the insurer's denial of claimant's aggravation claim for his C4-5 disc disease and related surgery; and (3) declined to address the compensability of his condition on an occupational disease theory. On review, the issues are res judicata and compensability of claimant's disc disease and related surgery as an aggravation or occupational disease. We affirm.

devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

Penalty-Related Attorney Fee

Claimant contends that he is entitled to a penalty-related attorney fee for the insurer's allegedly unreasonable failure to rescind its denial of his thoracic-dorsal condition until the day of the hearing. We agree.

As a preliminary matter, in the instant case, claimant does not allege that there were amounts then due on which to base a penalty for the insurer's allegedly unreasonable failure to rescind its denial. Therefore, a penalty cannot be assessed pursuant to ORS 656.262(10). However, ORS 656.382(1) provides for an assessed attorney fee when an insurer engages in conduct, which constitutes an unreasonable resistance to the payment of compensation, even though there are no amounts then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991).

A penalty or related-attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." The reasonableness of a carrier's denial of compensation must be gauged upon the information available to the carrier at the time of its denial. Mt. Mazama Plywood Co. v. Beattie, 62 Or App 355 (1983). After an insurer reasonably denies a claim, continuation of that denial in the light of new medical evidence becomes unreasonable only if the new evidence destroys any legitimate doubt. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

At the time the insurer issued its denial, Dr. Struckman indicated that claimant's back complaints might be related to congenital cervical anomalies. Therefore, at the time of its issuance, the denial was not unreasonable. However, in July 1990, Dr. Struckman specifically stated that claimant's work activities were the major cause of claimant's thoracic-dorsal condition. Also in July 1990, Dr. Erdman, who provided the only other medical opinion, stated that claimant's thoracic-dorsal condition was caused by the work activities.

Although the insurer had a legitimate doubt at the time it issued its denial, Dr. Struckman and Dr. Erdman's July 1990 letters removed this legitimate doubt with regard to the compensability of claimant's thoracic-dorsal condition. However, the insurer did not rescind that portion of its denial until April 12, 1991, the day of the hearing. We conclude that this constitutes an unreasonable resistance to the payment of compensation. Accordingly, claimant is entitled to a penalty-related attorney fee under ORS 656.382(1). See Tami L. Farrell, 43 Van Natta 2727 (1991); Richard J. Stevenson, 43 Van Natta 1883 (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 attorney's services concerning the insurer's unreasonable claims processing is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue the complexity of the issue, and the value of the interest involved.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. 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 attorney's services on review concerning the compensability of the cervical condition is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to

In the Matter of the Compensation of
SEAN T. BERK, Claimant
WCB Case No. 90-09395
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Gordon Welborn, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Fink's order that: (1) set aside its denial of claimant's claim for a cervical condition; (2) awarded an assessed attorney fee of $2,500, for services rendered at hearing. Claimant cross-requests review of those portions of the Referee's order that declined to award a penalty-related attorney fee for allegedly unreasonable claims processing. On review, the issues are compensability, amount of attorney fees and penalty-related attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

Claimant's counsel was instrumental in obtaining the rescission of that portion of the insurer's denial that denied claimant's thoracic-dorsal condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the conclusions and reasoning concerning the compensability of claimant's cervical condition as set forth in the Referee's order.

Attorney Fees

The Referee awarded claimant's counsel an assessed attorney fee of $2,500, for services at hearing. We agree.

The insurer's denial denied claimant's back condition in its entirety. Just prior to hearing, the insurer rescinded that portion of its denial concerning claimant's thoracic-dorsal spine. Thereafter, the parties proceeded to litigate the compensability of claimant's lumbar and cervical conditions. The Referee set aside the remainder of the insurer's denial. On appeal, only the compensability of claimant's cervical condition is at issue and we have herein affirmed the Referee with regard to the cervical condition.

Inasmuch as claimant has prevailed over the insurer's denial of claimant's lumbar and cervical conditions, he is entitled to an assessed attorney fee for services at hearing in regard to these conditions. See ORS 656.386(1) (amended June 19, 1991). Moreover, claimant's counsel was instrumental in obtaining the insurer's rescission of its denial of claimant's thoracic-dorsal condition. Therefore, he is also entitled to an assessed attorney fee for services rendered in conjunction with the rescission of that portion of the insurer's denial. Id.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the Referee's total award of a $2,500 assessed attorney fee, for services concerning the denial of claimant's lumbar and cervical conditions, as well as the services concerning the rescission of the denial of claimant's thoracic-dorsal condition, appropriately compensates claimant's counsel. In reaching this conclusion, we have particularly considered the time

In the Matter of the Compensation of
TODD S. ANDERSON, Claimant
WCB Case Nos. 90-09651, 89-26233, 90-09650 & 90-09649
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Claimant requests reconsideration of that portion of our January 6, 1992 Order on Review which modified the Arbitrator's attorney fee award of $2,500 and awarded claimant's counsel $1,800 for services at hearing. On reconsideration, claimant's counsel notes that the case involved 20 attorney hours and 10 hours of paralegal time. Claimant, therefore, requests that the attorney fee be increased to $3,500.

We decline to increase claimant's counsel's attorney fee award for services at hearing. We note that the primary issue in this case was responsibility, and a ".307" order had issued. Claimant was also present at hearing, however, on a penalty issue. The Arbitrator's order provides for an attorney fee on that issue, and we decline to base claimant's attorney fee for the responsibility issue upon participation or services rendered toward the penalty issue.

Moreover, we find that the hearing was a relatively brief one (approximately one and one-half hours), with the transcript reflecting 6 pages of direct examination of claimant and 3 pages of direct examination of a witness by claimant's counsel. We base our attorney fee, in part, upon the extent to which the examination involved the issue of responsibility, as we note that some of claimant's counsel's questions were directed toward the penalty issue.

Furthermore, SAIF conceded, and we acknowledged, that claimant's counsel actively participated in a pre-hearing deposition. Accordingly, although we base our attorney fee award, in part, upon that participation, we note the limited extent of participation in the deposition. The deposition was conducted by counsel for the insurers and, for the most part, consisted of questions by the insurers' attorneys. Before beginning her questions, claimant's counsel acknowledged that her questions would be "doubly redundant..." Tr. 63. Under the circumstances, we base our attorney fee award for such services upon the degree of participation exhibited in the record.

Finally, we also acknowledge that claimant's counsel originated correspondence, participated in telephone calls and traveled to the hearing. To the degree that such services were directed toward the responsibility issue, we agree that claimant's counsel is entitled to an attorney fee at hearing.

Under the circumstances, after considering the factors set forth in OAR 438-15-010(4), we continue to conclude that $1,800 is an appropriate attorney fee award for claimant's counsel's services at hearing, where the issue was responsibility and a .307 order had issued.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, subject to the foregoing supplementation, we adhere to and republish our January 6, 1992 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

right arm. Accordingly, we award no permanent disability for these scheduled body parts.

However, medical evidence does reveal a chronic cumulative trauma disorder involving the left upper arm that limits its repetitive use. (Exs. 27-3, 28-2). Accordingly, we award 5 percent scheduled permanent disability for this chronic condition. Former OAR 436-35-010(7).

Unscheduled Permanent Disability

Unscheduled disability is rated on impairment, as modified by age, education (including training and skills), and adaptability to perform a given job. Former OAR 436-35-270. However, where, as here, claimant has returned to her usual and customary work, no value is assigned to the age, education and adaptability categories. Former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a).

There is no medical evidence of impairment of claimant's neck. However, medical evidence establishes that the same chronic cumulative trauma disorder affecting claimant's left upper arm also limits the repetitive use of claimant's left shoulder. (Exs. 27-3, 28-2). Accordingly, we rate this chronic shoulder condition as a 5 percent impairment. Former OAR 436-35-320(4). Here, claimant returned to her usual and customary work as a meat packer. Therefore, we assign no values to the categories of age, education and adaptability. Former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a). Accordingly, claimant's unscheduled permanent disability under the standards is 5 percent.

Attorney Fees on Review

The request for review was filed by the insurer. We have found that claimant's compensation should not be disallowed or reduced. Hence, claimant's attorney is entitled to an assessed fee. 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 $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 9, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that set aside the insurer's July 11, 1990 Notice of Closure is reversed. The Notice of Closure is reinstated. In addition to the temporary disability awarded by the Notice of Closure, claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the left arm and 5 percent (16 degrees) unscheduled permanent disability for the left shoulder condition. The remainder of the order is affirmed. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased permanent disability compensation awarded under this order. However, the total approved attorney fees granted by this order and the Referee's order shall not exceed $3,800, payable by the insurer directly to claimant's attorney. For services on review regarding the compensability issue, claimant's attorney is awarded a $750 assessed fee, payable by the insurer.

date of closure. Medical reports offered after closure may be considered on the issue of whether the claimant was stationary at the time of closure. Scheuning, supra.

The resolution of the medically stationary date is primarily a question for competent medical experts. Harmon v. SAIF, 54 Or App 121, 125 (1985). The July 11, 1990 Notice of Closure did not address claimant's left neck, shoulder and arm conditions. However, at the time of closure, claimant had been examined and evaluated by Drs. Rosenbaum and Franks. Based on a May 11, 1990 examination, Dr. Rosenbaum opined that claimant's left carpal tunnel syndrome had been appropriately treated and that it was now medically stationary. He also opined that claimant's left neck and arm pain, for which a diagnosis had not yet been made, was related to her repetitive arm use at work, but he did not discuss possible improvement in that condition. (Ex. 21). Furthermore, Dr. Rosenbaum examined claimant again on November 30, 1990 and reported that claimant's condition was the same on both dates, which was confirmed by claimant's report to him. (Ex. 31A). Dr. Franks, claimant's former treating doctor for her carpal tunnel syndrome, found no objective basis for claimant's neck and shoulder symptoms, and found her medically stationary as to the carpal tunnel syndrome and released her to work as of June 6, 1990. (Ex. 23, 23A). In addition, Dr. Franks stated that his April 20, 1989 exam and Dr. Rosenbaum's May 1990 exam were identical, and he concurred with Dr. Rosenbaum's report. (Ex. 35).

When claimant consulted Dr. Long on July 26, 1990 after the Notice of Closure issued, he categorized her symptoms as mild and released her to regular work, opining that the symptoms would fade with normal activity. (Ex. 27-4). He prescribed physical therapy, which he discontinued in October 1990, noting that claimant had made no improvement. (Ex. 30). This indicates to us that there was no post-closure change in claimant's condition. Later, on December 5, 1990, Dr. Long indicated that claimant was not yet medically stationary and was not stationary on June 6, 1990. (Ex. 31-2). However, we do not find his December 1990 opinion persuasive because his conclusion is not supported by his earlier reports, and no explanation is given for his change of opinion. We accordingly conclude from the medical evidence that, at the time of claim closure, no further material improvement was reasonably expected from medical treatment or the passage of time. Consequently, we conclude that claimant's condition was medically stationary at the time the Notice of Closure issued. See ORS 656.005(17).

Extent of Permanent Disability

We therefore reinstate the insurer's July 11, 1990 Notice of Closure and proceed to rate the extent of claimant's disability according to the standards in effect on that date. See OAR 438-10-010 (WCB Admin. Order 11-1990). Claimant became medically stationary on June 5, 1990 and the Notice of Closure issued on July 11, 1990. We thus apply the January 1, 1989 Standards (WCD Admin. Order 7-1988). See former OAR 436-35-010(1) et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent partial disability and former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent partial disability.

Scheduled Permanent Disability

Scheduled disability is rated on the permanent loss of use or function of a body part listed in former ORS 656.214(2)(a) through (4), which includes the arm and hand. An impairment is a decrease in the function of a body part or system as measured by a physician. See former OAR 436-35-005 through 436-35-020. There is no medical evidence of impairment of claimant's left hand or

"legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id.

SAIF's claims adjustor received claimant's 801 form on April 10, 1990. He denied the claim on April 13, 1990 The only written documentation he had at the time of the denial was claimant's 801 form.. The adjustor concluded that notwithstanding the sudden onset of pain claimant said he experienced on the day of the reported injury, there was no "specific incident" as required for compensability, according to his own understanding of law. (Tr. 16). We conclude that the denial was precipitous, unreasonable, and based on an erroneous legal conclusion of the claims adjustor.

To be compensable as an injury, a condition need not arise as a result of some unusual occurrence, event or "accident" at work, as apparently the claims adjustor believed. A compensable injury may occur while the worker is performing "no more than the usual exertion on his job." Valtinson v. SAIF, 56 Or App 184, 187 (1982). The salient characteristics of a compensable injury is that the condition is unexpected, "sudden in onset" (although not necessarily instantaneous), occurring during a discrete period of work activity. Whether the employee's work activity was a material contributing cause of the condition is often a complex medical question, as it was in the present case.

Here, the employer did not deny that a work-related injury occurred, but rather admitted on the 801 form that it did not know if claimant was (or was not) injured on the job. (Ex. 6). The employer also reported on the form that: "Worker stated that he thought it happened at the scene of an emergency. Worker stated that his doctor thought this might have happened earlier but wasn't sure." (Ex. 6). Particularly since at this point, the claims adjustor had no inkling of the nature of claimant's disabling condition, these hearsay statements attributed to claimant, underscored the need to seek a diagnostic opinion from claimant's treating physician (Dr. Erkkila, who was identified on the 801 form as such) concerning the nature and probable cause of claimant's right foot condition.

The claims adjustor called Dr. Erkkila's office on the telephone and spoke to a "Martha," whose official capacity is not established by this record. According to the claims adjustor's testimony at hearing, "Martha" said that Dr. Erkkila was "unaware" that claimant had sustained a work-related injury. (Tr. 15). The claims adjustor did not speak to Dr. Erkkila. On April 13, 1990, the claims adjustor called claimant, who said that "he was unsure of how the injury occurred, only when the pain started." (Tr. 15). On the same day, the claims adjustor denied the claim, based on his conclusion that for a compensable injury, the law required a "specific incident," and there was none (Tr. 15-16).

A "legitimate doubt" cannot be said to exist, where, as here, a decision is quickly made, which prejudges the medical evidence available on the question of material contributing causation or interprets longstanding case law (e.g. Valtinson v. SAIF) more narrowly than the law actually provides.

We note in this regard that ORS 656.262(6) was amended in 1990 to allow insurers and self-insured employers 90 days, as opposed to the prior period of 60 days, to accept or deny a claim for compensation. Or Laws 1990 (Special Session), Ch. 2, 15. That amendment was applicable here. See Bryan L. Dunn, 43 Van Natta 1673 (1991). As explained in the legislative history, the intent behind the change was to avoid denials such as the one issued in this case. During the Senate Floor Debate on May 7, 1990, Senator Grensky explained that the period had been extended from 60 to 90 days to allow "better claims evaluations." Similarly, Representative Shiprack explained that "we wanted to give the insurer more time to accept or deny based upon the medical evidence that

would be received in the file * * *." Joint Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 14, Side B at 298. Moreover, Cecil Tibbets, a member of the Governor's Labor-Management Advisory Committee, testified that the provision was amended in order "to give a little more time for the insurance company to take a look. What we're trying to do with these changes is create more acceptances and less denials." Joint Interim Special Committee, May 3, 1990, Tape 1, Side B at 240.

We conclude that before its rush to judgment, SAIF did not have a legitimate doubt as to its liability for the claim, and we find its denial unreasonable. Accordingly, a penalty of 25 percent is appropriate in this instance.

Attorney Fee on Board Review

Claimant is also entitled to an assessed attorney fee for finally prevailing against SAIF's denial of compensability. ORS 656.386(1). Again, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's injury is $3,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 21, 1991 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. Claimant's attorney is awarded $3,500 for services at hearing and on review concerning the compensability of claimant's claim, to be paid by SAIF. For SAIF's unreasonable denial, claimant is awarded a penalty equal to 25 percent of the compensation due as of the date of hearing as a result of this order, payable by SAIF. This penalty shall be paid in equal shares to claimant and his attorney.

In the Matter of the Compensation of
RICHARD W. GREEN, Claimant
WCB Case No. 90-09964
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Daron's order which upheld the insurer's denial of claimant's head and neck injury claim. In its brief, the insurer contends that claimant's injury claim is barred due to an alleged failure to timely notify the employer and that the Referee erred in declining to admit Exhibits 12, 13 and 20 and portions of Exhibit 14, as well as testimony from two witnesses. Claimant asserts that the Referee improperly admitted Exhibits 14 and 19. On review, the issues are timeliness of the claim, compensability, and evidence. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of the claim

We first address the insurer's assertion that the claim is barred because claimant failed to timely notify the employer of his injury. Under ORS 656.265(1), notice of an accident resulting in an injury must be given to the employer within 30 days. Failure to give such notice bars a claim unless "[t]he employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice[.]"

The Referee concluded that the employer did have notice of the claim because, as manager of the company, claimant's "knowledge of the manager would be knowledge of the employer." (O & O, p. 6). Furthermore, the Referee found that claimant's injury was general office knowledge and, therefore, it was reasonable to conclude that other officers of the company were aware of it.

In assessing whether the employer has notice of a claim, knowledge of individuals in supervisory positions of an injury may be imputed to the employer. Colvin v. Industrial Indemnity, 301 Or 743, 747 (1986). However, if claimant himself is in a supervisory position, his own knowledge of his own injury does not qualify as notice to the employer. 3 Larson's Workman's Compensation Law 78.31(b)(2). We therefore disagree with the Referee's conclusion that claimant's own knowledge of his injury was notice to the employer. We further find, however, that there was evidence that claimant's son, the president of the company, was aware of claimant's injury shortly after his altercation with Mr. Smith. (Tr. 59). Consequently, the claim is not barred and we need not address the question of prejudice.

Compensability

The Referee concluded that the claim was not compensable based on his findings that claimant failed to establish his injury with medical evidence supported by objective findings or prove that his closed head injury was the major contributing cause of his complaints of dizziness, loss of memory, nausea/vomiting, and stress.

Under ORS 656.005(7)(a), a claimant must show that the claim "is established by medical evidence supported by objective findings[.]" A claimant may satisfy this requirement if he offers evidence that a physician has examined him and determined that he suffers from a disability or physical condition that requires medical services. Suzanne Robertson, 43 Van Natta 1505 (1991). That determination may be based on purely objective factors substantiated by clinical findings, see ORS 656.005(19), or a physician's evaluation of the physical condition based on the worker's description of the pain that she is experiencing, Suzanne Robertson, supra. Under the latter approach, however, the report must indicate that the claimant does, in fact, experience the symptoms and not merely recite the worker's complaints of pain. Id.

Claimant here asserts that his current symptoms of dizziness, nausea, loss of memory and stress are a result of the closed head injury that developed from his altercation with Mr. Smith. A report from Good Samaritan Hospital diagnoses claimant with closed head injury with vertigo. (Ex. 1-1). The examining physician also found neck tenderness, an unsteadiness on Romber testing, and that claimant was "unable to recall recent presidents or subtract serial 7's." (Ex. 1-2). That report is sufficient to satisfy ORS 656.005(7)(a) under Suzanne Robertson.

Claimant also must prove that his injury arose out of and in the course of employment. ORS 656.005(7)(a). Here, although we have found that claimant has

established objective findings, we agree with the Referee that there is no medical evidence that claimant's disability or need for treatment resulted from his head injury. Claimant, therefore, failed to prove a compensable claim for his closed head injury. In addition, we note that the Referee found that claimant was not a credible witness. Accordingly, we decline to rely upon claimant's version of the alleged altercation.

Because we conclude that claimant failed to prove causation, we do not address the applicability of ORS 656.005(7)(b)(A), which excludes from the definition of "compensable injury" "[i]njury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties[.]"

Evidence

Claimant objects to the Referee's admission of Exhibit 14, a set of medical records showing treatment of claimant before the injury, and Exhibit 19, the deposition transcript of Dr. Turco, psychiatrist, who examined claimant in January 1991 during an independent medical examination. Claimant argues that such evidence was not relevant to the issue of compensability, but rather only tended to show that claimant was not a "likeable individual" and that he was prejudiced by the admission of the evidence because the Referee relied on it to determine that claimant was not credible.

The insurer contends that the Referee erred in denying the admission of Exhibit 12, a list of lawsuits involving claimant and his company, Exhibit 13, copies of the complaints in those actions, those parts of Exhibit 14 which were denied, Exhibit 20, showing claimant's involvement in legal activities since the date of his injury, and the testimony of two witnesses describing claimant's anger.

We conclude that, even if the admission of Exhibits 14 and 19 and the denial of the evidence cited by the insurer was error, any error was harmless. The relevance of such evidence concerned either claimant's lack of credibility or the insurer's attempt to prove its "aggressor" defense under ORS 656.005(7)(b). The Referee and our order, however, primarily base the denial of the claim on claimant's failure to prove compensability and, in particular, causation. As we explained above, we expressly do not address the applicability of ORS 656.005(7)(b) and our holding does not solely depend on the Referee's finding that claimant lacked credibility. Moreover, in determining that claimant lacked credibility, the Referee relied upon claimant's prior statements, his testimony at hearing, and exhibits demonstrating claimant's involvement in the business following his injury. In no case did the Referee cite to evidence contained in Exhibits 14 and 19. Therefore, we conclude that any error in admitting or denying the cited exhibits and testimony was harmless.

ORDER

The Referee's order dated March 25, 1991 is affirmed.

In the Matter of the Compensation of
ARDIS L. HAMILTON, Claimant
WCB Case Nos. 90-17205, 91-03339, 90-10042
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation, on behalf of the Green Frog Restaurant, requests review of that portion of Referee Emerson's order which set aside its denial of claimant's aggravation claim for a neck and left shoulder condition. Claimant cross-requests review of that portion of the Referee's order which awarded an attorney fee. Claimant requests that the Board either clarify the attorney fee award or remand to the Referee for clarification. On review, the issues are remand, aggravation and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). A worsened condition is established with evidence of increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Leroy Frank, 43 Van Natta 1950 (1991). In addition, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1), (3). Finally, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

SAIF contends that claimant did not prove that her neck and shoulder condition has worsened since she was awarded 30 percent unscheduled permanent partial disability in January 1987, the last arrangement of compensation. SAIF further argues that, assuming claimant's condition has worsened, such worsening is no more than the waxing and waning of symptoms contemplated by the permanent disability award.

After claimant injured her neck and left shoulder in September 1985, she was treated by Dr. Utter, D.C. He found that claimant's symptoms could be attributed to two factors: "the soft tissue injury of the left side of the thoraco-cervical area" and "a complicating blood pressure problem." (Ex. 7-1). Dr. Buza, neurosurgeon, who saw claimant on referral from Dr. Utter, diagnosed claimant as suffering from a "cervical strain." (Ex. 5-2). An independent medical examination conducted by Dr. Paluska, orthopedic surgeon, also found "traumatic strain of cervical spine" with "mild to moderate functional overlay" by claimant. (Ex. 10-2).

Claimant returned for further treatment with Dr. Utter in March 1990, complaining of increasing symptoms in her neck and left shoulder. Dr. Utter took her off work, stating that she was not medically stationary and "in an aggravation status." (Ex. 19-2). Utter found "marked degenerative change at the C6, C7 level" as well as a "nodular lump on the right side adjacent to the carotid artery." (Id.) Utter stated that, "[b]ecause of the nodular lump which may

interfere with the vascular flow[,] I believe this is related to her initial 1985 industrial injury." (Id.)

Utter referred claimant to Dr. Barber, M.D. Barber first stated that "it is not clear to me exactly what is going on with [claimant.]" (Ex. 15-1). After claimant underwent a CAT scan, however, Barber could find no cause for her symptoms, stating that he was "suspicious that most of this is mental rather than physical" in view of a report that she earlier had been to the emergency room "with what sounds like typical anxiety reaction and hyper ventilation." (Ex. 15-2).

Utter also referred claimant again to Dr. Buza. He diagnosed musculoligamentous strain and degenerative disc disease, but stated that he did not believe that "clinically [claimant] has changed since I last saw her." (Ex. 20-3).

Utter subsequently reported that the degenerative changes he noted could be attributed to the "soft tissue injury involving the cervical spine [which] resulted in instability of this area and over a period of time materially worsened[.]" (Ex. 22). Utter also stated that claimant's work activities at the doughnut shop did not cause the worsening of her condition. (Id.) Utter then completely reversed his opinion following an independent medical examination of claimant during which she stated that her increased symptoms were from her work at the doughnut shop. Based on claimant's statements, Utter found that "it would be my opinion that her current aggravation resulting in the increasing pain and disability is from work at the doughnut shop." (Ex. 27-1). A subsequent report reinforced this conclusion, stating that the "only reasonable explanation for her marked increasing subjective symptoms and outstanding objective findings is her work exposure at" the doughnut shop. (Ex. 30-1).

Finally, claimant underwent two independent medical examinations by the Western Medical Consultants. In each case, claimant was diagnosed with "degenerative osteoarthritis, cervical spine" and that "psychologic factors appear to be playing a prominent part in [claimant's] symptoms." (Exs. 24-5, 37-5). The first report stated that claimant's "present complaints do not bear any relationship to her industrial injury of 1985, with the exception that in most cases she complained of some neck symptoms. In our opinion, degenerative changes in the cervical spine have been progressing as a result of natural aging since 1986 and, in respect to her industrial injury of 1985, it is our opinion that her condition remains medically stationary." (Ex. 24-5). Dr. Buza concurred with these findings. (Ex. 34-1).

In considering whether claimant proved that her condition had worsened, we give Utter's opinion no weight in light of the inconsistencies in his reports as to the cause of claimant's increased symptomatology. The remaining medical evidence provides no proof that claimant's condition has either worsened, or that any worsening is a result of her compensable 1985 injury. Dr. Barber could find no cause for claimant's symptoms, stating that her neck and shoulder symptoms were probably due to "mental" factors. Dr. Buza found no change in claimant's condition from his initial examination in December 1985 to his most recent examination in March 1990. The Western Medical Consultants also could not attribute claimant's symptoms to her 1985 accident, noting that psychological factors figured prominently in the cause of her symptoms. We therefore are persuaded that claimant failed to prove a worsened condition resulting from the original injury.

Attorney Fees

Claimant contends that this case should be remanded "for reconsideration regard[ing] delineation of attorney fees awarded for services on reversing two denial letters that were dated May 23, 1990 and July 20, 1990."

The Referee awarded a lump sum attorney fee of $2,000 "for prevailing against SAIF Corporation's (Green Frog) rejection of the aggravation claim." Contrary to claimant's contention, the Referee did not award an attorney fee to claimant for prevailing on two issues even though the order set aside the May 23, 1990 denial and set aside the July 20, 1990 denial to the extent that the "current condition" for which responsibility was denied purported to include claimant's neck and left shoulder condition. Moreover, because we conclude that claimant has not established that her current neck and left shoulder conditions are related to her 1985 compensable injury, we also reverse that portion of the Referee's order which awarded an attorney fee.

ORDER

The Referee's order dated April 5, 1991 is reversed in part and affirmed in part. That portion which set aside SAIF's denial of claimant's aggravation claim is reversed. The attorney fee award is reversed. The remainder of the order is affirmed.

January 30, 1992 Cite as 44 Van Natta 157 (1992)

In the Matter of the Compensation of
DOUGLAS IVES, Claimant
WCB Case No. 90-22013
ORDER ON REVIEW
Craig Creel, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant, pro se, requests review of Referee Daughtry's order that: (1) upheld the insurer's denial of claimant's back injury claim; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. With his appellant's brief, claimant has submitted several reports not admitted as evidence at the hearing. We treat such a submission as a motion for remand for the taking of additional evidence. ORS 656.295(5). On review, the issues are remand, compensability, penalties, and attorney fees.

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

We may remand for further evidence if we determine that a case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

The evidence which claimant submits on review primarily consists of reports concerning claimant's eligibility for health insurance, statements concerning events which occurred at an October 1990 banquet, and letters/statements from individuals who did not testify at the hearing. Most of these materials pertain to claimant's civil rights action stemming from his employment termination. Furthermore, claimant acknowledges that his former attorney failed to call several of these individuals as witnesses.

After considering claimant's submission for purposes of determining whether remand should be granted, we conclude that remand is not warranted. We base our conclusion on the following reasoning.

Here, the issue for our resolution is not contingent on whether claimant was eligible for health insurance benefits. Rather, the salient issue is whether claimant suffered a back injury while performing his work activities and, if so, whether that injury was a material contributing cause of his need for medical services or disability.

We are not persuaded that the record concerning the matter for our resolution has been improperly, incompletely or otherwise insufficiently developed. Moreover, claimant's former attorney's alleged failure to call several witnesses to testify does not mean that the evidence to be derived from their testimony was unobtainable with due diligence at the time of hearing. Finally, even if all the materials submitted by claimant were considered as evidence, the medical record continues to consist of claimant's treating physician's unpersuasive equivocal opinion that it is "just as likely" that claimant injured his back while moving his residence than it is that his back injury occurred while performing his work activities. Inasmuch as claimant must establish by a preponderance of the evidence that his alleged work injury was a material contributing cause of his need for medical services or disability, such a medical opinion would be insufficient to satisfy his burden of proof.

ORDER

The Referee's order dated August 5, 1991 is affirmed.

In the Matter of the Compensation of
LARRY A. KITE, Claimant
WCB Case No. 91-01064
ORDER OF DISMISSAL
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

The SAIF Corporation requested review of Referee T. Lavere Johnson's order that: (1) set aside the Director's order suspending claimant's temporary disability compensation pursuant to ORS 656.325; and (2) awarded claimant temporary disability benefits. On January 16, 1992, we approved the parties' Claim Disposition Agreement (CDA), in which claimant agreed to fully release his rights to all workers' compensation benefits (including temporary disability), except medical services, for his compensable injury. WCB Case No. C1-02706.

Noting our approval of the CDA, SAIF seeks dismissal of its request for review. SAIF states that the CDA "takes care of the appeal issue." Considering that the issue on review pertains to claimant's temporary disability benefits and in light of our approval of the parties' CDA, we conclude that the issue raised by SAIF's appeal of the Referee's order has been resolved in accordance with the CDA. In other words, claimant is not entitled to additional temporary disability benefits as previously granted by the Referee. Consequently, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT E. RIEGEL, Claimant
WCB Case No. 90-21453
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of those portions of Referee Neal's order that: (1) awarded claimant temporary total disability benefits [TTD] from August 29 through October 30, 1990; (2) assessed a penalty to be shared equally by claimant and his attorney for allegedly unreasonable failure to pay TTD; and (3) assessed a separate penalty-related attorney fee for unreasonable failure to pay TTD. In his brief, claimant requests that: (1) he be awarded a penalty for the employer's late payment of TTD due for the period from October 31 through December 4, 1990; and (2) in the event the Board reverses the Referee's award of a separate penalty-related attorney fee, his counsel be awarded 25 percent of the increased compensation created by the Referee's award of additional TTD. On review, the issues are temporary total disability, penalties, and attorney fee. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, as stated in her first "Opinion" section, and her "Ultimate Findings of Fact," with the following correction. Dr. Litman, psychologist, examined claimant on October 31, 1990.

In addition, we supplement with the following. Dr. Brookhart, claimant's attending physician, has treated claimant for his severe anxiety depression/stress syndrome since the onset of his disability. By letter to the employer dated September 14, 1990, in which he stated "[claimant] continues to be unable to work because of his psychological problems suffered because of his on-the-job situation," Dr. Brookhart verified that claimant was unable to work due to his work-related condition. Further, he copied the employer with his September through October 1990 chart notes documenting claimant's continuing severe work-related mental stress condition.

Claimant filed his request for hearing on November 27, 1990; the hearing was held on February 6, 1991.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue is not subject to a special exception to the Act's general applicability provision. See, e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Temporary Total Disability August 29, 1990 through October 30, 1990

The Referee found that Dr. Brookhart, claimant's attending physician, consistently has stated claimant is unable to work because of his work-related

mental stress condition. Accordingly, the Referee found claimant is entitled to TTD benefits for the period August 29 through October 30, 1990. We agree, and affirm and adopt the Referee's reasoning and conclusion as set forth in her second "Opinion" section through the first paragraph on page four, as supplemented below.

Subsection (4)(b) of amended ORS 656.262 requires, for time loss to be payable, that an attending physician provide verification of the worker's inability to work due to the work-related condition. The new subsection provides:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control." Or Laws 1990 (Special Session), ch. 2, 15. (Emphasis supplied).

On review, the employer argues that TTD is not due and payable when "objective" verification of time loss has been requested from but not provided by the attending physician. More specifically, the employer asserts that ORS 656.262(4)(b) authorizes an employer to withhold time loss until it has received a report that is sufficient to establish compensability. The employer therefore exhorts the Board to "give effect to the amendments of ORS 256.005(7)(a) [sic] and 656.262(4)(b) and hold that objective findings from claimant's physician are required to verify the worker's inability to work when requested by the employer and that in the absence of such findings temporary disability benefits are not due and payable, as expressly provided by the legislature." [Emphasis supplied]. App. Brief, pg. 10. (ORS 656.005(7)(a) provides, in pertinent part, that "[a] 'compensable injury' is [one that is] established by medical evidence supported by objective findings. . . ." Or Laws 1990 (Special Session), ch. 2, 3).

We find no support in the legislative history for the employer's assertion that the legislature intended ORS 656.262(4)(b) to be interpreted in conjunction with ORS 656.005(7)(a). There was no legislative discussion, express or implied, concerning objective findings insofar as they relate to an attending physician's verification of a worker's inability to work due to a work-related condition. To the contrary, there is but a single, terse statement in the record explaining subsection (4)(b) of SB 1197, 15. In commenting on the proposed legislation, R. Dwinell, a member of the Labor/Management Committee, testified only that "[I]f authorization for time loss is not given by the attending physician, time loss is not owed." Joint Committee Proceedings, May 3, 1990, Tape 1, side B at 160. There was no subsequent discussion on the topic.

Moreover, the legislature did not expressly provide an "objective" verification criteria within the statute. The plain meaning of the statute is clear: All that is required to support entitlement to time loss is verification, or authorization, by an attending physician. We decline to read an "objective findings" requirement into the statute when the legislature has omitted such a standard. See ORS 174.010; State ex rel Cox v. Wilson, 277 Or 247 (1977); SAIF v. Severson, 105 Or App 67, 71 (1990). To paraphrase Mr. Dwinell, if authorization for time loss is given by the attending physician, time loss is owed.

We find, as did the Referee, that Dr. Brookhart, by his letter dated September 14, 1990 wherein he stated "[claimant] continues to be unable to work because of his psychological problems suffered because of his on-the-job situation," verified claimant's inability to work due to his work-related condition

during the period in question. Furthermore, we find that Dr. Brookhart's chart notes and letters to the employer, regarding his and other consulting specialists' efforts to arrange appropriate psychiatric or psychological treatment for claimant, document claimant's inability to work due to his work-related condition.

Consequently, we conclude claimant did all that was required to establish his entitlement to TTD from August 29 through October 30, 1990. The employer was without authority to withhold TTD benefits for this period.

Penalty for Nonpayment of TTD

Finding the employer unreasonably failed to pay time loss for the period between August 29 and October 30, 1990, the Referee assessed a penalty to be shared equally by claimant and his attorney.

On review, the employer argues that it expressly complied with the terms of ORS 656.262(4)(b) which authorize an employer to withhold time loss until it has received a report that is sufficient to establish compensability. Therefore, the employer asserts, its conduct in withholding TTD benefits is presumptively reasonable. We have addressed the employer's contention regarding objective findings above. ORS 656.262(4)(b) imposes no such statutory requirement.

In the alternative, the employer asserts that its reliance upon an erroneous statutory interpretation was reasonable. We find no support for that assertion either. Here, in contrast to the cases cited by the employer, the employer was not relying upon a former statute or rule or prior case law in interpreting the amended statute, but rather upon its own interpretation. Under these circumstances, we find the employer's reliance on its own interpretation of the statute was not reasonable.

Consequently, we affirm the Referee's penalty award for the period August 29 through October 30, 1990.

Attorney Fee at Hearing

In addition to one-half of the penalty, the Referee also awarded claimant's counsel a separate penalty-related attorney fee. The employer argues that under amended ORS 656.262(10), the amount paid to an attorney for a penalty is in lieu of an attorney fee. We agree.

The factual basis asserted by claimant in support of the fee, i.e., unreasonableness of the employer's refusal to pay time loss from August 29 through October 30, 1990, is the same factual basis for which the penalty under ORS 656.262(10)(a) was assessed. Under such circumstances, claimant's attorney is only entitled to receive one-half of the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991). Therefore, we reverse the Referee's award of a separate $800 penalty-related attorney fee.

In the alternative, claimant notes the Referee awarded him additional temporary disability benefits, yet did not approve an attorney fee to be paid out of this increased compensation. Claimant's fee agreement with his attorney provided for an approved fee equal to 25 percent of any increased compensation awarded at the hearing level, not to exceed $1,050, to be paid out of the increased compensation. Thus, claimant contends, the Referee should have approved an attorney fee payable out of the increased TTD awarded by her order.

We agree. See OAR 438-15-045. Because the Referee did not approve an out-of-compensation attorney fee, we do so now. For his efforts at hearing in

obtaining additional TTD benefits, claimant's counsel is awarded an approved fee equal to 25 percent of the increased compensation created by the Referee's order, in an amount not to exceed $1,050, to be paid out of the increased compensation to claimant's counsel by the employer.

Penalty for Late Payment of TTD

Claimant also seeks penalties for the employer's late payment of TTD from October 31 through December 4, 1990. Claimant has already been awarded the penalties he seeks, with the exception of penalties for the period from November 24 through December 4, 1990. In her order, the Referee found the employer paid "some" of the time loss due for this period late. Therefore, in addition to her award of penalties for nonpayment of TTD from August 29 through October 30, 1990, the Referee awarded claimant and his attorney penalties for late payment of TTD from October 31 through November 23, 1990. The employer has not challenged this portion of the Referee's order.

Thus, claimant is entitled to additional penalties, if at all, only for late payment of TTD benefits due from November 24 through December 4, 1990. However, none of those TTD benefits were paid late. On December 7, 1990, the employer paid claimant all TTD due and owing from October 31 through December 4, 1990. Compensation must be paid no later than the fourteenth day after it is due. ORS 656.262(4)(a). Thus, as of its December 7, 1990 payment, the employer was current on all amounts owed claimant. There is no statutory basis for imposition of a penalty for amounts due after November 23, 1990.

Attorney Fee on Board Review

Claimant is entitled to an assessed attorney fee for prevailing against the employer's request for review. After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $800 is a reasonable fee for claimant's counsel's services on review concerning the TTD issue. 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 to claimant.

Inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the Referee's penalty and attorney fee awards. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 15, 1991 is affirmed in part, modified in part, and reversed in part. That portion of the order which awarded claimant's counsel an $800 penalty-related attorney fee is reversed. The Referee's order is modified and, for his efforts at hearing in obtaining additional TTD benefits, claimant's counsel is awarded an approved fee equal to 25 percent of the increased compensation created by the Referee's order. However, such amount shall not exceed $1,050, and shall be paid out of the increased compensation created by the Referee's order to claimant's counsel by the self-insured employer. The remainder of the order is affirmed. For services on review concerning the TTD issue, claimant's attorney is awarded a reasonable assessed fee of $800, payable by the employer.

In the Matter of the Compensation of
MARGARET I. BOEHR, Claimant
WCB Case No. 89-21774
ORDER ON REMAND (REMANDING)
Michael B. Dye, Claimant Attorney
Ronald Pomeroy (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). The court reversed our order which declined to award an attorney fee pursuant to ORS 656.382(1) when the SAIF Corporation took 35 days to comply with a discovery request which was made before a hearing request had been filed. In reaching our conclusion, we reasoned that even if SAIF's delay in providing discovery was unreasonable, claimant was not entitled to an attorney fee award because there was no evidence that the discovery delay had delayed the acceptance of the claim.

Citing Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), the court concluded that an attorney fee may be awarded for a discovery violation even when there is no evidence that the violation delayed acceptance of the claim. However, relying on Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991), the court reasoned that in order to find an unreasonable resistance to compensation, the claim must be compensable. Inasmuch as our prior order did not determine whether the underlying claim was compensable and, if so, whether SAIF's delay was unreasonable, the court remanded for reconsideration.

Inasmuch as SAIF has offered no explanation for its failure to provide discovery until 35 days after claimant's request, we consider the record to be sufficiently developed to determine whether SAIF's conduct was unreasonable. Nevertheless, there is no evidence in the record from which to determine whether "the underlying claim was compensable." Consequently, we consider the record concerning this issue to be insufficiently developed for us to proceed with our reconsideration. Under such circumstances, we are authorized to remand a case to the Referee for the taking of additional evidence. ORS 656.295(5).

Accordingly, this matter is remanded to Referee Brazeau for further proceedings. The Referee is instructed to take additional evidence solely on the issue of whether "the underlying claim was compensable." Boehr v. Mid-Willamette Valley Food, supra, at page 295. The proceeding to present this additional evidence shall be conducted in any manner that will achieve substantial justice. After admission of the additional evidence and consideration of the parties' arguments, the Referee shall issue a final, appealable Order on Remand determining: (1) whether the underlying claim was compensable; (2) if so, whether SAIF's delay in providing discovery was unreasonable; and (3) if so, whether an attorney fee pursuant to ORS 656.382(1) should be awarded. Id.

IT IS SO ORDERED.

In the Matter of the Compensation of
LYNDIA M. BRISTOL, Claimant
WCB Case No. 90-22440
ORDER ON REVIEW
Douglas Minson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Tenebaum and Kinsley.

Claimant requests review of that portion of Referee Neal's order that affirmed the August 14, 1990 Determination Order award of 61 percent (195.2 degrees) unscheduled permanent disability for a low back condition and 31 percent (46.5 degrees) scheduled permanent disability for the loss of use or function of her right leg. In its respondent's brief, the insurer contests that portion of the order that assessed a penalty for its failure to timely pay an attorney fee. Claimant has submitted a motion to dismiss the insurer's request. On review, the issues are dismissal, permanent total disability, and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Dismissal

Claimant has moved to dismiss all issues raised in the insurer's brief because it had not filed a formal request for review. We have previously held that, as part of our de novo review, we have the authority to consider issues that are raised other than by a formal cross-request for review. See Jeffery A. Guild, 42 Van Natta 191 (1990); Kenneth Privatsky, 38 Van Natta 1015 (1986). Accordingly, claimant's motion to dismiss is denied.

Permanent Total Disability

The threshold requirement to recover increased permanent disability is a greater permanent injury than that which existed at the time of the prior award. Accordingly, when a claimant who has not previously been awarded permanent total disability asserts a claim for such benefits following an aggravation claim, claimant must first prove, by a preponderance of the evidence, a permanent worsening of the condition resulting from the compensable injury. Stepp v. SAIF, 304 Or 375 (1987); Smith v. SAIF, 302 Or 396 (1986).

After our review, we conclude that claimant has failed to carry her burden. In fact, the record indicates that claimant's compensable condition has actually improved since the reopening of her claim for additional low back surgery in November 1989. Dr. Eilers, the treating physician who performed the surgery, reported that claimant was "70 to 80 percent better" than she had been over the two years prior to the surgery. This would include the time of her last award on January 20, 1989 as well as the prior Determination Order of September 30, 1988. (Ex. 48). Even claimant testified at hearing that her condition had improved since the last reopening. There is no contrary evidence. Accordingly, we conclude that claimant is not entitled to an award of permanent total disability.

Penalties

The insurer contends that the Referee erred in assessing a penalty for its late payment of an attorney fee awarded by the January 20, 1989 Opinion and Order. We disagree.

ORS 656.262(10) provides, in pertinent part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation * * * the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due." (Emphasis supplied.)

The attorney fee at issue here was ordered to be paid out of compensation awarded by the prior referee. Because an attorney fee payable out of an award is part of a claimant's compensation, claimant was entitled to an additional amount under ORS 656.262(10) for the insurer's failure to timely pay that compensation. See Weyerhaeuser Co. v. Sheldon, 86 Or App 46 (1987).

Inasmuch as a penalty is not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the insurer's contention in its respondent's brief that the Referee's assessment of a penalty should be reversed. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated March 26, 1991 is affirmed.

In the Matter of the Compensation of
HAROLD W. BYNUM, Claimant
WCB Case No. 90-14661
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Moller.

The self-insured employer requests review of Referee Mongrain's order which set aside its denial of compensability of claimant's heart condition. On review, the issue is compensability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except the last full paragraph on page 2 and the findings following that paragraph. We supplement the adopted findings as follows.

Claimant has preexisting coronary heart disease (a 50 percent atherosclerotic plaque in the mid-portion of the right coronary artery). On April 27, 1990, immediately following claimant's heated verbal confrontation with a co-worker at work, claimant had a myocardial infarction. He left work because of pain in his chest, which radiated into his left arm, but he did not seek medical treatment.

On May 5, 1990, while off work and after having coffee with friends in a restaurant, claimant had another episode of chest pain which was even more severe than the pain he experienced during and after the work incident on April 27, 1990. Due to the two episodes of chest pain, claimant sought medical treatment and was ultimately hospitalized.

FINDINGS OF ULTIMATE FACT

The severe emotional stress claimant experienced during the confrontation with a co-worker on April 27, 1990 combined with claimant's preexisting heart

disease to cause claimant's myocardial infarction on the day of the confrontation.

The April 27, 1990 work incident was a material contributing cause of claimant's disability on that day. The work incident was also a material contributing cause of claimant's need for medical treatment after the second episode of chest pain on May 5, 1990.

Claimant has not established, however, that the April 27, 1990 work incident was the major contributing cause of his disability and need for medical treatment on and after May 5, 1990.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant has proven that he had a compensable injury on April 27, 1990 which was a material contributing cause of the myocardial infarction claimant suffered on that day. Whether claimant suffered a myocardial infarction caused, in material part, by the stressful work incident, is a complex medical question which the Referee resolved in claimant's favor, based primarily on the medical opinion of Dr. Dienel. We adopt the Referee's reasoning and conclusions that claimant established that he suffered a compensable injury on April 27, 1990, under the material contributing cause standard which applied. Bahman M. Nazari, 43 Van Natta 2368 (1991). However, the Referee did not address the issue of whether the compensable injury is and remains the major contributing cause of claimant's disability and need for treatment on and after the May 5, 1990 episode of chest pain. Since the issue was litigated at hearing and is raised on Board review, we address the issue.

Claimant has preexisting coronary heart disease. We have found, based on Dr. Dienel's persuasive reports, that claimant's myocardial infarction on April 27, 1990 was due to a combination of work related stress and claimant's preexisting disease. Therefore, although claimant has proven that there was a compensable injury on April 27, 1990, in order to obtain compensation for his disability and medical treatment after that single episode, claimant must, under ORS 656.005(7)(a)(B), also establish by a preponderance of the evidence that the compensable April 27, 1990 injury is the major contributing cause of his disability and need for medical services. Bahman M. Nazari, supra. The causal relationship, if any, between the April 27, 1990 episode, the May 5, 1990 episode which occurred off work, and claimant's disability and need for medical treatment after May 5, 1990 is a complex medical evidence which requires expert medical opinions to be resolved. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Claimant relies primarily on the opinion of Dr. Dienel, cardiologist. As stated previously, we also consider Dr. Dienel's opinion to be the most persuasive.

In his December 5, 1990 report (Ex. 10), Dr. Dienel opined that claimant's myocardial infarction on April 27, 1990 was "temporarily related" to the verbal altercation on that day. According to Dr. Dienel, the 50 percent narrowing in the mid-right coronary artery was not enough to precipitate the heart attack. However, the severe emotional stress claimant was under during the verbal altercation caused claimant to have a coronary spasm which increased the area of obstruction beyond the preexisting 50 percent obstruction. This resulted in the myocardial infarction "shortly after that altercation." (Ex. 10).

In his February 25, 1991 report (Ex. 13), Dr. Dienel further explained that the sudden emotional stress on April 27, 1990 precipitated a "transient coronary spasm" which was the "most probable cause for the event occurring on April 27, 1990." Furthermore, claimant "has not sustained a severe myocardial

infarction and . . . he is not disabled as a result of that myocardial infarction." (Ex. 13-4).

Dr. Dienel also stated:

> "It is equally true, however, that because of that episode of chest pain and the subsequent episode occurring on May 5 that he did require medical attention, that he did require hospitalization and finally coronary arteriography. I also agree that because Mr. Bynum had one episode this does not predispose him necessarily for future episodes of coronary spasms nor does this episode suggest a worse long-term prognosis for this individual." (Ex. 13-4) (Emphasis added).

Dr. Dienel opined that the second episode of chest pain on May 5, 1990 was not a myocardial infarction, but instead was angina. (Ex. 13-4). It is undisputed that claimant sought treatment after the angina attack which was more painful than the myocardial infarction. Dr. Dienel did not offer an opinion as to the cause of the angina. Furthermore, there is no evidence in the record to show that the angina was causally related, in any degree, to the work incident or to the resulting myocardial infarction. In fact, we understand Dr. Dienel to opine that the myocardial infarction was essentially an isolated incident brought on by a combination of job stress and the preexisting heart disease.

Claimant has the burden of establishing that his work injury on April 27, 1990 was the major contributing cause of his disability and need for treatment after that incident. Claimant sought medical treatment only after he had the severely painful angina episode. It is doubtful that he would have sought medical treatment without that episode (and speculation, in any event). Since the angina episode occurred off work and the evidence does not establish that it was caused by the myocardial infarction, we are unable to conclude that the work injury was the major contributing cause of claimant's disability and/or need for medical services on and after May 5, 1990. Accordingly, although claimant has established the occurrence of a compensable injury on April 27, 1990, his claim for current medical treatment and/or disability is not compensable.

The Referee set aside the employer's denial and awarded an assessed fee. We are reinstating and upholding a portion of that denial. The Referee's assessed attorney fee shall be adjusted accordingly. In addition, claimant has, in part, successfully defended against the employer's request for review. He is, therefore, entitled to an assessed fee on review. ORS 656.382(2). In lieu of the Referee's fee, we award a reasonable assessed fee for services at hearing and on review concerning compensability of the April 27, 1990 injury, in the amount of $1,800. We have arrived at this fee after considering the factors set forth in OAR 438-15-010(4). In particular, the time devoted to this issue (as represented by the hearing record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

We adopt the Referee's reasoning and conclusion that claimant was not an active participant in an assault within the meaning of ORS 656.005(7)(b)(A).

ORDER

The Referee's order dated April 23, 1991 is affirmed in part and modified in part. The employer's May 25, 1990 denial is set aside in part and upheld in part. That portion which denied that claimant sustained a compensable injury on April 27, 1990 is set aside. That portion which denied claimant's current medical services and/or disability is upheld. In lieu of the Referee's assessed attorney fee award, claimant is awarded a reasonable fee for services at hearing and on Board review concerning the compensability of the April 27, 1990 injury, in the amount of $1,800, to be paid by the self-insured employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
LEONARD L. FETTER, Claimant
WCB Case Nos. 90-18890 & 90-17823
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Livesley's order which: (1) upheld the SAIF Corporation's denial of a herniated disc on behalf of Bi-Mor Stations; (2) upheld the SAIF Corporation's partial denial of claimant's herniated disc on behalf of Starfire Lumber; and (3) declined to assess penalties and attorney fees against Bi-Mor for an allegedly unreasonable denial. On review, the issue is compensability.

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

The Referee found the credibility of the witnesses to be determinative of the issue of compensability. Based on his observations at hearing, the Referee found one of the defense witnesses, Smith, to be credible based on her demeanor and manner of testifying.

Claimant contends that the Referee incorrectly found claimant's testimony to be inconsistent. Claimant asserts that the Board can just as easily find the two defense witnesses to be non-credible based on inconsistent testimony.

When the Referee makes specific findings on credibility based upon attitude, appearance and demeanor, great weight and deference should be given to the Referee. Bush v. SAIF, 68 Or App 230, 233 (1984). However, we are not statutorily mandated to accept the Referee's credibility findings. Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). After our de novo review of the record, we find no reason to reject the Referee's credibility finding.

Smith testified that the day after the alleged injury, claimant asked her to take over his shift because he had injured his back. Smith testified that claimant told her he hurt his back out in the woods while cutting fire wood. The Referee found Smith credible based on her demeanor. We also find Smith credible. Smith attended the hearing under subpoena. The employer had fired her because her till was a dollar short. Smith stated she did not think she had been treated fairly. Smith stated she was "pissed" about being fired. We conclude, as did the Referee, that Smith was a disinterested witness, who, if anything had a reason to testify unfavorably against the employer.

We find the testimony of SAIF's witnesses to be believable and that any alleged inconsistencies or contradictions in their testimony are not significant enough to destroy their credibility. We conclude that claimant has failed to meet his burden to prove that his disc herniation is compensable.

ORDER

The Referee's order dated April 8, 1991 is affirmed.

In the Matter of the Compensation of
JOHN K. FRENCH, Claimant
WCB Case No. 90-17809
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of those portions of Referee McWilliams' order that: (1) upheld the self-insured employer's partial denial of claimant's herniated lumbar disc condition, degenerative disc disease and degenerative arthritis; and (2) declined to address claimant's contention of entitlement to additional temporary total disability with penalties and related attorney fees for the employer's allegedly unreasonable failure to pay temporary disability compensation. On review, the issues are compensability, temporary total disability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant is a 45-year-old machinist who has worked for the employer for over 20 years. In 1967, claimant injured his back in a motor vehicle accident. He was placed in traction for 30 days and experienced back symptoms for several months, but made a recovery. In 1985, claimant sought treatment from the Veterans Administration for a variety of problems that included degenerative disc disease and arthritis with associated back and leg pain. X-rays taken in 1986 were interpreted as showing "minor degenerative disease; otherwise normal lumbar spine." (Ex. 1-3). In 1987, a physician suspected that claimant was suffering from a low lumbar cord trauma. (Ex. 1-16).

On October 25, 1989, claimant injured his low back at work while moving parts on a drill press. He sought treatment from Dr. Damond, a chiropractor, who diagnosed lumbosacral strain with sciatic neuralgia. (Ex. 7). A November 14, 1989 MRI of the lumbosacral spine showed degenerative disease with associated disc bulging and Schmorl's nodes, but no evidence of herniation or nerve root encroachment. (Ex. 4). Claimant subsequently filed a claim for compensation, which the employer accepted as a nondisabling injury.

Claimant was examined by Dr. Woolpert, an independent medical examiner, on January 17, 1990. No objective findings of impairment were found other than reports of buttock irritation with straight leg raising and left calf decreased sensation. Dr. Woolpert diagnosed a lumbosacral strain and degenerative disc disease. (Ex. 12).

On February 22, 1990, the employer issued a "back-up" denial of the previously accepted claim on the grounds that claimant had misrepresented his condition when he failed to disclose his prior low back problems.

In July 1990, claimant transferred his care to Dr. Johnson, M.D. Shortly thereafter, claimant had a second MRI scan that was interpreted as showing "degenerative disc disease in virtually all levels" with "a more prominent bulge on the right at the L4-5 level [that] suggests a small herniated nucleus pulposus." (Ex 27). Following the MRI, Dr. Johnson performed a complete physical on claimant and diagnosed, among other things, a herniated disc at L4-5. (Ex. 28).

On August 17, 1990, claimant was examined by Dr. Campagna, on referral from Dr. Johnson. Based on a medical history provided by claimant, Dr. Campagna diagnosed a protruded L4 disc that he believed was secondary to the October 1989

injury. He offered no opinion as to the status of the degenerative condition, which he acknowledged pre-dated the 1989 injury.

On August 24, 1990, Referee Brown issued an order finding claimant's low back strain compensable and setting aside the employer's February 1990 "back-up" denial. The order remanded the claim "for acceptance and payment of compensation due." (Ex. 30). On August 30, 1990, the employer accepted the claim as ordered and, with the understanding that claimant had been released to regular work as of March 12, 1990, submitted the claim for closure. It also issued a partial denial of claimant's herniated lumbar disc, lumbar degenerative disc disease and degenerative arthritis. (Ex. 32). The following day, on August 31, 1990, the employer filed a request for Board review of Referee Brown's order.

On October 9, 1990, the Department issued a Determination Order finding claimant medically stationary on January 19, 1990, and awarding temporary total disability through that date. The Department rescinded that Determination Order on October 24, 1990, however, evidently in response to Dr. Johnson's report that claimant was not medically stationary and that he had been released to return to work only on a trial basis.

Claimant subsequently filed a request for hearing, challenging the employer's August 30, 1990 partial denial and seeking commencement of temporary total disability. The hearing was convened on December 12, 1990.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation savings clause contained in section 54(2) does not apply. In addition, the compensability and temporary total disability issues are not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Raymond J. Seebach, 43 Van Natta 2687 (1991); Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the law as amended, effective July 1, 1990.

Compensability - Herniated Disc

The Referee found that the herniated disc, which she evidently classified as a "consequence of a compensable injury," was not compensable because claimant had failed to prove that the October 1989 injury was the "major contributing cause" of his disability or need for treatment. ORS 656.005(7)(a)(A). We agree with the Referee's ultimate conclusion, but offer the following analysis.

As amended, ORS 656.005(7)(a) provides, in pertinent part:

> "A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." Or Laws 1990 (Special Session), ch. 2, 3.

Subsequent to the Referee's order, we issued Julie K. Gasperino, 43 Van Natta 1151 (1991), in which we construed the phrase "consequential condition" to include only conditions that arise from conditions previously deemed compensable, as opposed to conditions that allegedly arose directly from the injurious event. Accordingly, we held that the 1990 amendments to the definition of a compensable injury did not affect the standard of compensability for conditions intrinsically related to the underlying compensable event.

In this case, we conclude that claimant's herniated disc is not properly classified as a "consequential condition" within the meaning of ORS 656.005(7)(a)(A). Claimant seeks compensation for a condition that he alleges was directly caused by the October 1989 industrial accident, rather than as a "consequence" of the compensable low back strain he sustained in that accident. Therefore, in order to establish compensability, claimant need only show that the October 1989 accident was a material contributing cause of his disc herniation and need for medical services.

Nonetheless, after our review of the record, we conclude that claimant has failed to carry that burden. Only two expert opinions on medical causation were introduced in this matter. Dr. Johnson, claimant's treating physician, and Dr. Campagna, who examined claimant in August 1990, both expressed the opinion that claimant's disc herniation was related to the October 1989 industrial injury. Both physicians, however, fail to explain why the November 1989 MRI scan failed to reveal a disc herniation less than a month after that injury. As noted by the Referee, the radiologist who interpreted the scan expressly noted that "there is no sign of herniation." (Ex. 4). Yet, in rendering their respective opinions, neither physician addressed this relevant and obvious omission. In light of claimant's extensive degenerative disc disease with associated degenerative arthritic changes, we find that the physicians' failure to address this issue detracts from the reliability of their opinions. Accordingly, we find neither opinion persuasive and give them little weight. See Somers v. SAIF, 77 Or App 259 (1986).

After our review of the record, we find that the record contains insufficient medical evidence to establish that claimant's October 1989 work-related injury was a material contributing factor to his herniated disc condition. Accordingly, we affirm the Referee's determination upholding the employer's denial.

Compensability - Degenerative Disc Disease and Degenerative Arthritis

We adopt the conclusions and reasoning concerning the compensability of claimant's degenerative disc disease and degenerative arthritis, as set forth in the Referee's order.

Entitlement to Temporary Total Disability

Claimant contends that he is entitled to temporary total disability compensation for his low back strain and that the employer has unreasonably resisted the payment of such benefits. He cites Referee Brown's August 24, 1990 Opinion and Order, which found that the low back strain was compensable and directed the employer to pay any compensation due. The employer, however, filed a request for Board review of that order on August 31, 1990. Consequently, it was entitled to stay the payment of compensation appealed under ORS 656.313. See Raymond J. Seebach, supra.

Claimant next contends that, notwithstanding the request for review, the employer was required to pay any temporary total disability benefits that accrued from the date of the appealed order. We agree. See ORS 656.313(1)(a)(A).

We must determine, therefore, whether claimant was entitled to receive temporary disability compensation from August 24, 1990.

Temporary total disability benefits are awarded to replace wages lost as a result of temporary disability. Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). A claimant is entitled to temporary total disability compensation for that period of time, prior to becoming medically stationary, when he is unable to work as the result of a compensable injury. Soledad Flores, 43 Van Natta 2504 (1991).

The primary medical evidence on this issue comes from Dr. Johnson and Dr. Woolpert. On October 16, 1990, Dr. Johnson indicated that, in his opinion, claimant's lumber strain was not medically stationary and that he had not been released to work. On the other hand, Dr. Woolpert expressed the opinion that claimant's strain had long since resolved and that any current disability was most likely caused by claimant's underlying degenerative disc disease.

When there is a dispute between medical experts, we give greater weight to those opinions that are both well reasoned and based on complete information. Somers v. SAIF, supra. After our review of the record, we find that only Dr. Woolpert's opinion meets both criteria and, accordingly, give it the most weight. We are not persuaded by Dr. Johnson's opinion, because it is conclusory and not thoroughly explained. He offers no explanation why claimant's lumbar strain remains nonstationary after a year of treatment and does not distinguish between disability for claimant's lumbar strain and disability for his noncompensable degenerative disc disease or degenerative arthritis. Consequently, we afford it little weight.

In contrast, Dr. Woolpert's opinion is well reasoned and persuasive. He explained that, in January 1990, claimant's low back strain was not medically stationary. At that time, however, he thought that claimant would soon become medically stationary after he received the additional strengthening and therapy at the Pacific Institute of Rehabilitation. He further explained that any additional treatment or disability thereafter would be related to claimant's underlying degenerative disc disease, adding that soft tissue sprains usually resolve within six months.

After our review of the record, we conclude that claimant has failed to establish that, as a result of his compensable low back strain, he was temporarily disabled for the period after August 24, 1990, the date of the prior referee's order, up to December 12, 1990, the date of the recent hearing. Inasmuch as no compensation has accrued, there was no unreasonable resistance to the payment of compensation for which a penalty may be assessed.

ORDER

The Referee's order dated January 11, 1991 is affirmed.

In the Matter of the Compensation of
MICHAEL A. JAQUAY, Claimant
WCB Case No. 90-19632
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members en banc.

The insurer requests review of Referee Hoguet's order that: (1) set aside its denial of claimant's medical service claim for diagnostic services; and (2) awarded claimant an assessed fee of $2,500 for his counsel's services in overturning the denial. In his respondent's brief, claimant renews his motion to strike two exhibits from the record. On review, the issues are admissibility of evidence, medical services and attorney fees. We affirm.

FINDINGS OF FACT

On November 7, 1989, claimant compensably injured his left knee in a work-related motor vehicle accident. He immediately sought treatment at a local emergency room, where he was diagnosed as having a left knee contusion. X-rays proved negative, and claimant received conservative treatment.

Claimant continued to complain of knee pain and sought treatment from Dr. Mandiberg, an orthopedist, during late 1989 and early 1990. Dr. Mandiberg noted several inconsistencies in claimant's symptoms and stated that he had "a real hard time believing [that claimant was] injured significantly." (Ex. 11).

On June 19, 1990, claimant was examined by Dr. Logan, an orthopedic surgeon, at the offices of the Orthopaedic Consultants. Dr. Logan found little evidence of an existing knee injury and believed that claimant was overreacting to the stimuli during examination. He concluded that, in his opinion, "there was nothing from a neurologic or orthopedic point of view to treat further at this time." (Ex. 13-5).

On June 22, 1990, claimant sought treatment from Dr. Eidenberg, an orthopedist, who recommended physical therapy for claimant's continued left knee pain. Claimant did not believe the therapy would be beneficial and declined the treatment.

On July 19, 1990, a Determination Order issued, awarding claimant 2 percent scheduled permanent partial disability for the loss of use of his left knee. Claimant was deemed medically stationary on June 19, 1990.

On August 20, 1990, claimant consulted Dr. Brenneke, an orthopedist, for continued left knee pain. Dr. Brenneke diagnosed internal derangement of the knee and recommended a diagnostic arthroscopy. He believed that claimant's symptoms were consistent with certain injuries that are not easily detected by an x-ray or MRI scan. The insurer denied the request, asserting that the need for treatment was unrelated to claimant's compensable injury.

CONCLUSIONS OF LAW AND OPINION

Before proceeding with our review, we note that a hearing was previously held to determine the compensability of claimant's left knee condition. In a May 18, 1990 Opinion and Order, the prior Referee found the injury compensable and set aside the insurer's denial. On March 27, 1991, we issued an Order on Review, which affirmed and adopted the prior Referee's order.

Admissibility of Evidence

An initial issue raised by claimant is the admissibility of two surveillance video tapes, which were admitted into the record as exhibits 19 and 20. After examining the exhibits, we conclude that, although we are not convinced that they impeached claimant, we find that the insurer, in good faith, offered them for the purposes of impeachment and we agree with the Referee that they are admissible on that basis.

Medical Services - Jurisdiction

A threshold issue, which is not addressed by either party, is whether we have jurisdiction to resolve this medical treatment dispute under the 1990 amendments to the workers' compensation law. Or Laws 1990 (Special Session), ch. 2. Specifically, we must decide whether the treatment at issue here is subject to the procedure set forth in ORS 656.327, so that original jurisdiction over this matter rests with the Director rather than the Hearings Division. ORS 656.704(3); see Stanley Meyers, 43 Van Natta 2643 (1991). As relevant, ORS 656.327 provides a procedure for the resolution of disputes concerning treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of [administrative] rules."

Here, the insurer denied the diagnostic procedure on the ground that the need for the procedure was not related to the compensable injury. In this regard, ORS 656.245(1) requires that an insurer or self-insured employer provide medical services "for conditions resulting from the [compensable] injury." (Emphasis supplied.) Thus, this dispute concerns the question whether, pursuant to ORS 656.245(1), the need for the proposed diagnostic service is causally related to the compensable injury. The issue here is not the appropriateness of the treatment under ORS 656.327(1). Inasmuch as there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship issue, we hold that such disputes are "matters concerning a claim" over which we have original jurisdiction. See ORS 656.704(3).

This conclusion is supported by the legislative history. As we noted in Meyers, supra, a member of the Governor's Workers' Compensation Labor-Management Advisory Committee testified that the purpose of the amendments to ORS 656.327 and 656.704 was to remove questions concerning the reasonableness and necessity of medical treatment from the litigation process and allow such decisions to be made by a physician rather than a referee. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 75. There is no suggestion in the legislative history that it was the intent of the legislature to remove causal relationship questions from the litigation process. Accordingly, we conclude that we properly have jurisdiction of this medical treatment dispute.

Medical Services - The Merits

The Referee first found claimant credible based on demeanor. We defer to that finding. Humphrey v. SAIF, 58 Or App 360 (1982). The Referee then concluded that the proposed arthroscopy is compensable, finding that claimant's compensable injury is a material contributing cause of his current need for treatment. We agree.

An injured worker is entitled to medical services "for such period as the nature of the injury or the process of recovery requires, including such medical services as may be required after a determination of permanent disability." ORS 656.245(1)(a). A diagnostic service, such as the proposed arthroscopy, is compensable if the need for the service is related to the compensable injury.

Brooks v. D & R Timber, 55 Or App 688, 692 (1982); Priscilla J. Bosley, 43 Van Natta 380 (1991).

In this case, claimant credibly testified that he has pain on the top and left side of his knee, that his symptoms increase with crawling, climbing and heavy lifting, and that his symptoms have not significantly changed since his compensable injury. He has consulted several physicians for his persistent knee symptomology, but has received little relief from conservative treatment. In August 1990, he consulted Dr. Brenneke, who noted loss of motion in extension and slight loss of flexion in the knee. After a review of claimant's medical record, Dr. Brenneke believed that the exact diagnosis of claimant's condition was yet undetermined and proposed to perform a diagnostic arthroscopy. He explained the specific need for the diagnostic procedure as follows:

"The need for a diagnostic arthroscopy would be to evaluate the inside of the knee. MRI's have a fairly good rate of diagnostic accuracy, yet there are a number of findings that the MRI will not find such as articular cartilage disease and some meniscal tears. This could certainly lead to the troubles that [claimant] is describing. Otherwise, I have no other treatment for him. He has had physical therapy and all other modalities, and they have not been successful." (Ex. 18).

Based on that report, as well as the evidence cited above, we conclude that claimant has established that the need for the arthroscopy is materially related to the compensable injury. Accordingly, we affirm that portion of the Referee's order setting aside the insurer's denial.

In reaching our decision, we note that the insurer appears to challenge the compensability of claimant's knee condition, asserting that proposed treatment is not compensable "because the existence of a continuing injury to claimant's knee had long since ceased to be supported by an objective findings, if such findings ever truly existed." (App. brief at 2). It relies on reports submitted by Dr. Mandiberg and Dr. Logan, who both noted "functional" components to claimant's symptoms and found little evidence of an existing knee injury. (Exs. 11, 13).

We are not persuaded by the insurer's argument. First, the compensability of claimant's knee condition is not at issue. That issue was litigated before the prior Referee, who found objective evidence that claimant sustained a compensable injury. Second, a Determination Order, which issued after the reports filed by Dr. Mandiberg and Dr. Logan, established as a matter of law that claimant sustained a permanently disabling injury as a consequence of the compensable injury. Consequently, we give little weight to their opinions.

Attorney Fees

The Referee awarded claimant a $2,500 attorney fee, to be paid by the insurer, for his counsel's services in overturning the denial. On review, the insurer contends that the attorney fee awarded was excessive under the circumstances.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $2,500 adequately compensates claimant's counsel's efforts at hearing. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue presented, and the value of the interest involved. Based on similar considerations, we find that $1,000 is a reasonable assessed fee for claimant's counsel's efforts in defending on the issue of medical services on Board review. 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 January 3, 1991 is affirmed. For services rendered on Board review, claimant is awarded a reasonable attorney fee of $1,000, to be paid by the insurer.

January 31, 1992 Cite as 44 Van Natta 176 (1992)

In the Matter of the Compensation of
CARL J. JOHNSON, Claimant
WCB Case No. 90-21860
ORDER ON REVIEW
Stunz, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Peterson's order that set aside its partial denial of claimant's low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" as supplemented.

By late 1989, following his November 1988 lumbar laminectomies and lumbosacral fusion, claimant was functioning quite well. He had returned to full-time light duty work and, as he had missed no time from work, was going to bid for a heavier job. He had resumed his preoperative level of social and recreational activities.

Dr. Johnson examined claimant on January 18, 1990 and noted lumbosacral spine and right iliac spine tenderness with significantly increased lumbosacral pain. Accordingly, he diagnosed a lumbosacral strain in addition to claimant's pseudoarthrosis.

Independent consulting physicians Drs. Giest and Watson examined claimant on October 16, 1990. They noted markedly restricted ranges of motion, a slight left limp, atrophy of the left thigh and calf, and diagnosed a lumbosacral strain occurring January 1990.

Due to the January 1990 injury which disrupted the stability of his pseudoarthrosis, claimant is unable to return to his at-injury job and is severely restricted in his level of social and recreational functioning.

Claimant filed his request for hearing on December 6, 1990; the hearing was held on March 19, 1991.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue is not subject to a special exception to the Act's general applicability provision. See, e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the

purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Turning to the merits of the claim, the Referee found the industrial accident of January 1990 was the cause of claimant's lumbosacral strain and the major contributing cause of the worsening of his pseudoarthrosis and current need for medical treatment. Accordingly, relying on ORS 656.005(7)(a)(B), he set aside the insurer's denial. We agree, and adopt the Referee's reasoning and conclusion, with the exception of the fourth sentence in the first full paragraph on page three, as supplemented.

On review, the insurer argues that the Referee should not have relied on x-ray findings, which reflect claimant's 1988 laminectomies and fusion, as objective medical evidence of a worsening of claimant's low back condition after the January 9, 1990 accident. We agree. However, we do not agree with the insurer's implied contention that there are, therefore, no objective findings substantiating a worsening of claimant's low back condition. "Objective findings" in support of medical evidence include "diagnostic evidence substantiated by clinical findings." ORS 656.005(19). Here, Dr. Johnson noted tenderness of the lumbosacral spine and right iliac spine with significantly increased lumbosacral pain, and diagnosed a lumbosacral strain. Moreover, Drs. Giest and Watson concur that claimant sustained a lumbosacral strain in January 1990. Because Drs. Johnson, Giest and Watson have determined, based on their examinations, that claimant sustained a lumbosacral stain, their reports constitute medical evidence supported by objective findings. See, e.g., Suzanne Robertson, 43 Van Natta 1505 (1991). Accordingly, we too find claimant's lumbosacral strain compensable. See Mark N. Wiedle, 43 Van Natta 855 (1991).

ORS 656.005(7)(a)(B), however, limits the compensation to which a worker may be entitled in a compensable injury claim. Under that provision, a worker who suffers a compensable injury, yet who also suffers from a preexisting condition or disease that combines with the injury to cause or prolong disability, will be compensated for disability and treatment only if the compensable injury is the major contributing cause of the disability or need for medical treatment. See Bahman M. Nazari, 43 Van Natta 2368 (1991).

Without any explanation or discussion, Drs. Giest and Watson opine that claimant's preexisting pseudoarthrosis, rather than the January 1990 industrial injury, is the major contributing cause of claimant's current low back condition and need for treatment. We do not find their cursory and unexplained conclusion to be persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Dr. Johnson has treated claimant continuously since his prior laminectomies and fusion, and originally diagnosed claimant's pseudoarthrosis condition. When he examined claimant after the January 1990 accident, Dr. Johnson expressed concern that the trauma of claimant's fall could disrupt the stability of his pseudoarthrosis. Based on claimant's increased and uncontrolled back pain and decreasing work tolerance, yet normal neurological examinations, the doctor has concluded claimant has mechanical back pain due to destabilization of his pseudoarthrosis. We find Dr. Johnson's well-reasoned opinion to be persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

Finally, we find no merit to the insurer's argument that because, claimant's noncompensable heart condition renders him an unsuitable candidate for surgery to correct his pseudoarthrosis, the compensable injury of January 1990 did not "cause a need for medical treatment of claimant's back."

Consequently, we further find that claimant has proven by a preponderance of the evidence that the compensable January 1990 injury was and remains the major contributing cause of his current back condition and need for medical treatment. See Bahman M. Nazari, supra. Accordingly, we agree that Liberty's partial denial of claimant's low back condition should be set aside in its entirety.

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under 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 assessed attorney fee for claimant's counsel's services on review is $900, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case as represented by claimant's statement of services, and the value of the interest involved.

ORDER

The Referee's order dated March 25, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $900, payable by the insurer.

In the Matter of the Compensation of
DALE W. LEBOLD, Claimant
WCB Case Nos. 90-13311, 90-08646, 90-09926 & 90-13299
ORDER ON REVIEW (REMANDING)
Burt, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney
Stoel, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

Les Schwab, a self-insured employer, requests review of that portion of Arbitrator Brazeau's order that: (1) set aside its responsibility denial of claimant's low back condition; and (2) upheld the SAIF Corporation's responsibility denial of the same condition. Claimant cross-requests review of that portion of the order that declined to award attorney fees for services rendered at hearing. On review, the issues are responsibility and attorney fees. We review for questions of law, ORS 656.307(2), and remand.

We summarize the Arbitrator's findings. In March 1984, claimant injured his back while working for Les Schwab. His symptoms included low back pain radiating down the left leg to the foot. A myelogram revealed a disc fragment at the L5-S1 level on the left. In June 1984, Dr. Gallagher, an orthopedic surgeon, performed an L5-S1 laminectomy and disc excision. Les Schwab accepted the claim, and claimant was ultimately awarded 25 percent unscheduled permanent disability.

In May 1985, claimant began working for SAIF's insured delivering oil products. During the following five years, he successfully performed strenuous work without significant difficulty, although his low back and left leg symptoms continued to some degree. His symptoms significantly increased in April 1990, however, and he returned to Dr. Gallagher for additional treatment. In addition to low back and left leg pain, claimant also suffered from "drop foot" on the left. Imaging studies revealed chronic degeneration of the L5-S1 disc and increased L5 neural foraminal stenosis. The study also showed chronic

degeneration and spurring of the L4-5 disc. Shortly thereafter, Dr. Gallagher performed a decompression of the L5 nerve root with foraminotomy and a disc excision at L4-5.

Claimant filed claims against Les Schwab and SAIF following his surgery. Les Schwab denied responsibility on April 19, 1990, asserting that claimant had sustained a new injury at SAIF's insured. SAIF denied responsibility on May 7, 1990, and requested the designation of a paying agent. On June 22, 1990, an order issued pursuant to ORS 656.307, designating Les Schwab as the paying agent pending the outcome of the arbitration proceeding.

The Arbitrator found that claimant's 1984 injury did not contribute to claimant's current back condition. Nonetheless, he concluded that Les Schwab remained responsible for claimant's current condition, because there was no persuasive evidence that claimant sustained a new compensable injury while working for SAIF's insured. In reaching his decision, he applied section 49(1) of Senate Bill 1197, which provides, in part:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition." Or Laws 1990 (Special Session), ch. 2, 49.

On review, Les Schwab contends that the Arbitrator erroneously construed section 49. It agrees that, in the usual case, the first employer remains responsible unless it can establish that the worker has sustained a new compensable injury or disease involving the same condition. It contends, however, that the legislature could not have intended the application of that provision to hold the first employer responsible in cases, such as this, where the first employer establishes that there is no causal connection between the worker's first employment and his current condition.

We agree that the result reached by the Arbitrator was somewhat anomalous. The Arbitrator recognized that fact himself. Nonetheless, the reason for that result was not caused by a misapplication of section 49, but rather by the fact that both carriers had conceded that claimant's current condition was compensable with the issuance of a ".307" order. Under the circumstances, one carrier, by definition, had to be responsible for claimant's medical treatment or disability, even though the medical evidence at the time of hearing may not have supported compensability. Accordingly, the responsibility for claimant's condition was properly analyzed under section 49.

In applying that provision, however, the Referee concluded that responsibility remained with Les Schwab because "there is no persuasive evidence that claimant's employment at [the SAIF's insured] independently contributed to a pathological worsening of his compensable low back condition." (Arb. Order at 4). From that language, it appears that the Arbitrator applied the old standard for determining whether claimant had sustained a new injury for purposes of assigning responsibility. See Linda L. Wise, 42 Van Natta 115 (1990). Subsequent to the Arbitrator's order, we issued Ricardo Vasquez, 43 Van Natta 1678 (1991), in which we concluded that a worker does not sustain a new injury for responsibility purposes under section 49 unless the new standards of compensability are met. Thus, in order to shift responsibility to SAIF, Les Schwab had to establish that claimant sustained either a new compensable injury under ORS 656.005(7)(a), or an occupational disease under ORS 656.802. See Rosalie S. Drews, 44 Van Natta 36 (January 10, 1992); Donald C. Moon, 43 Van Natta 2595 (1991).

The Arbitrator's order is not consistent with the applicable law. Accordingly, because our review is limited to questions of law, we remand this matter to the Arbitrator for proper application of law. ORS 656.307(2); ORS 656.295(5); Thomas N. Thorn, 42 Van Natta 2325 (1990).

ORDER

The Arbitrator's order dated October 30, 1990 is vacated. This matter is remanded to Arbitrator Brazeau for further action consistent with this order.

In the Matter of the Compensation of
KEVIN E. POMPE, Claimant
WCB Case No. 91-02872
ORDER ON REVIEW
Karen Werner, Claimant Attorney
Paul L. Roess, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Quillinan's order which directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issues are the res judicata effect of a prior stipulated settlement and the rate of scheduled permanent disability.

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

The Referee concluded that claimant's August 13, 1990 Stipulated award of scheduled permanent disability should be paid at the rate of $305 per degree. We agree.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the 1990 Oregon Laws, chapter 2, section 7 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability to $305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because claimant's award of scheduled permanent disability was made after May 7, 1990, the Referee correctly concluded that the award should be paid at the rate of $305 per degree.

The insurer argues that claimant is barred by res judicata from asserting that he is entitled to be paid at the rate of $305. The insurer asserts that, in a stipulated settlement and order of dismissal dated August 13, 1990, the parties agreed to dismiss the request for hearing "with prejudice as to all issues raised or raisable." (Ex. 3-2). The insurer contends that claimant could have raised the issue of rate of payment at the time that the stipulation was entered into and, therefore, is precluded now from litigating that issue.

We reject the insurer's contention. The parties' stipulation did not provide for payment of the award at any particular rate. Until the insurer elected to pay the award at $145 per degree, no justiciable controversy existed between the parties. Therefore, the rate issue was not "raisable" at that time. See Drews v. EBI Companies, 310 Or 134, 142-43 (1990).

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the insurer's request for review. See 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 rate of permanent disability issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated May 22, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $500, to be paid by the insurer.

In the Matter of the Compensation of
PHILIP H. RANDALL, Claimant
WCB Case No. 90-04691
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Otto's order which upheld the insurer's denial of chiropractic treatment for claimant's left chest wall strain. On review, the issue is compensability of medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as clarified. Rather than lifting 30 pound silicon wafers, claimant lifted plates containing silicon wafers which weighed 25 to 30 pounds. The Western Medical Consultants examined claimant on December 20, 1989 only. On July 18, 1990, they submitted an addendum to their December 20, 1989 report to the insurer.

ULTIMATE FINDINGS OF FACT

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

CONCLUSIONS OF LAW

Preliminary Matter

On review, the insurer does not challenge the Referee's conclusion that claimant's chiropractic treatment was not reasonable and necessary. Nonetheless, the insurer argues that the Board lacked authority to convene an accelerated hearing on this matter on June 27, 1990. As we concluded in John K. French, 43 Van Natta 836 (1991), there is no statutory provision that prohibits the Board from rescheduling or accelerating the date of a hearing, provided that it gives ten days prior notice of the time and place to all parties in interest by mail. See ORS 656.283(5). Furthermore, the Board is charged with overall responsibility to refer a request for hearing to a Referee for determination as expeditiously as possible, and that hearing is to be scheduled for a date not more than 90 days after the receipt by the Board of the request for hearing, except in extraordinary circumstances. ORS 656.283(4). Accordingly, as the parties in the present case were given timely notice, we conclude that the hearing

convened on June 27, 1990 was procedurally legal and proper. See John K. French, supra. Consequently, we agree with the Referee that this case should be analyzed under the law existing prior to July 1, 1990. 1990 Oregon Laws (Special Session), ch 2, Section 54(2).

Reasonableness and Necessity of Medical Services

We affirm and adopt the Referee's reasoning and conclusions on this issue with the following comment.

Evidence that palliative treatments enable a worker to work is a significant factor supporting a determination that such treatments are reasonable and necessary. West v. SAIF, 74 Or App 317, 321 (1985). However, we do not interpret West as establishing such evidence as a prerequisite to the compensability of palliative care. Rather, we look to a number of factors. Such factors include but are not limited to: the degree to which claimant's pain is reduced so that he is able to function; the period of time during which claimant enjoys the benefits of the treatment; whether claimant undergoes treatment on a scheduled basis or an "as-needed" basis; whether claimant has suffered permanent disability as a result of his compensable injury; and, more generally, whether the persuasive medical evidence supports or opposes the reasonableness and necessity of treatment. Rodney C. Anderson, 41 Van Natta 818, 820 (1989).

After considering the above factors as a whole, we agree with the Referee that claimant has not proven by a preponderance of the evidence that chiropractic treatments from December 1989 through July 16, 1990 were reasonable and necessary.

ORDER

The Referee's order dated March 11, 1991 is affirmed.

January 31, 1992 Cite as 44 Van Natta 182 (1992)

In the Matter of the Compensation of
WILLIAM G. RICE, Claimant
WCB Case Nos. 90-19769 & 90-19768
ORDER OF DISMISSAL
Emmons, et al., Claimant Attorneys
Gatti, et al., Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Attorney Charles Maier requests review of Referee T. Lavere Johnson's order which denied a "Petition for Attorney Fees." On review, the issue is whether the Hearings Division has jurisdiction to consider the petition. We vacate the Referee's order and dismiss the petition.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Under ORS 656.283(1), "any party or the director may at any time request a hearing on any question concerning a claim." "Party" is defined as "a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." ORS 656.005(20). Under this provision,

"party" does not include attorneys representing a claimant, whether former or not. See, e.g., Adams v. Transamerica Insurance Group, 45 Or App 769, 774 (1980) (Because he was claimant's attorney, plaintiff was not a party and therefore could not appeal the Board order at issue); Berliner v. Weyerhaeuser Company, 92 Or App 264, 266 n. 1 (1988) ("[C]laimant is the only party claiming that he did not receive the [Board's] order; his attorney asserts that he did not receive it either"); Wendy S. Reyes, 43 Van Natta 1249 (1991) (former attorney lacks authority to appeal Referee's order); Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989) (applying Berliner to conclude that attorneys are not "parties" within the statute).

In this case, Mr. Maier is claimant's former attorney. As an attorney, he does not qualify as a "party" and, therefore, cannot request a hearing under ORS 656.283(1). The Hearings Division thus lacked jurisdiction to consider Mr. Maier's petition for attorney fees.

Mr. Maier also moves to "disallow" claimant's reply brief because it was not timely filed. Claimant's brief asserts that Referee Johnson lacked jurisdiction to issue an order because Mr. Maier does not qualify as a party.

Subject matter jurisdiction may be addressed by the Board at any time in the course of litigation, whether or not raised at the hearing below and whether or not raised by the parties or the Board. See Schlecht v. SAIF, 60 Or App 449, 451 (1982). Therefore, assuming that the reply brief was not timely filed, we may address the issue of subject matter jurisdiction on our own initiative whether or not claimant failed to timely raise it in his reply brief. Accordingly, we continue to conclude that we are without jurisdiction in this matter.

ORDER

The Referee's order dated May 10, 1991 is vacated for lack of subject matter jurisdiction and Attorney Maier's petition for attorney fees is dismissed.

January 31, 1992 Cite as 44 Van Natta 183 (1992)

In the Matter of the Compensation of
MARILEE B. RUTHERFORD, Claimant
WCB Case No. 90-11343
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Fink's order which upheld the self-insured employer's denial of her occupational disease claim for a mental disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Under ORS 656.802(1)(b), "occupational disease" includes any mental disorder which requires medical services or results in physical or mental disability or death. The worker must prove that employment conditions were the major contributing cause of the disease and establish its existence with medical evidence

supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation; there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

The Referee concluded that claimant failed to satisfy any of the elements necessary to prove her claim under ORS 656.802. The Referee, in part, based his conclusion on the opinion of Dr. Parvaresh, psychiatrist, who conducted an independent medical examination. Dr. Parvaresh concluded that claimant "does not have sufficient psychiatric impairment to preclude her from returning to work but obviously she wants to air and resolve what she considers unjust treatment by her supervisor and the manager of the department." (Ex. 4-6). The Referee gave no weight to the opinion of Dr. Johnson, claimant's treating psychiatrist, who found that claimant has been suffering from depressive neurosis for several years due to her work environment and that, after the incident involving Wicht, her mental condition worsened into major depression. (Ex. 5-1, 2).

Claimant asserts that Dr. Johnson's opinion is the more reliable evidence concerning claimant's emotional condition and that this evidence proves her claim under ORS 656.802. We conclude that, even taking into account Dr. Johnson's opinion, claimant failed to prove her claim to be compensable.

Although claimant's brief alleges that claimant's condition was caused in part by a stressful working environment, including substantial overtime and workload, the medical evidence clearly indicates that she felt "discounted" and as if "her feelings did not matter" to her supervisors, thereby causing her to become depressed. In particular, Dr. Johnson found that claimant's emotional condition began deteriorating several years ago, when her supervisors told her that her production was too low. (Ex. 5-3). The report states that claimant's failure to receive any performance evaluations, be promoted, or receive wage increases also contributed to her decline. (Id.) Johnson found that, although claimant was depressed, her condition became disabling when she walked into the cubicle of a co-worker, and observed his naked buttocks. Importantly, Johnson does not find that the actual observance of the naked buttocks was the triggering event, but rather concluded that management's handling of the incident caused claimant to "feel victimized" and precipitated a major depression.

Claimant's statements to Dr. Parvaresh support Dr. Johnson's opinion that claimant was stressed by her supervisors' perceived failure to promote her or give her raises and performance evaluations. (Ex. 4-2). In regards to the incident involving the co-worker, the report indicates that claimant was angry that management did not take disciplinary action and she was concerned the co-worker could have sexual problems. (Id.)

In determining whether employment conditions exist in a real and objective sense, we examine whether the events underlying claimant's mental condition are real, as opposed to imaginary, and are capable of producing stress. Duran v. SAIF, 87 Or App 509, 513 (1987). This question does not include whether claimant's perception of the events is reasonable or not, because the medical effect of the events is measured by the actual reaction, rather than by an objective standard of whether the conditions would have caused disability of an average worker. Peterson v. SAIF. 78 Or App 167, 170, rev den 301 Or 193 (1986).

In this case, the evidence proves that claimant did receive pay raises, having been at the top of the scale for claims examiners until shortly before she left her job. Moreover, claimant received performance evaluations through

1988. In those evaluations, claimant was told that she was "conscientious and accurate," "thorough," and had a "good attitude." (Exs. 10, 11). Evaluations were not given in 1989 and claimant left before 1990 evaluations. For the most part, therefore, claimant's belief that she did not receive performance evaluations is not real and objective.

In regards to the co-worker incident, it is undisputed that claimant observed his exposed buttocks. As stated above, this event was stressful to claimant because she believed that management did not sufficiently investigate the incident or discipline the co-worker. The record proves, however, that the office manager, Sylvia Sherman, met with claimant and the co-worker about the incident. The co-worker told Sherman that he had jock itch and had pulled his pants down to view the rash and scratch. Sherman told the co-worker that his behavior was unacceptable and that he would be terminated if it was ever repeated. Memos written by claimant and Sherman describing the incident were placed in the co-workers personnel file. We conclude that, although the event was real, claimant's belief that it was not sufficiently investigated or that the co-worker was not disciplined are not based on actual events. Moreover, there was evidence to support the co-worker's explanation that he suffered from jock itch and the record does not substantiate claimant's concerns that the co-worker suffered from problems of a sexual nature.

The record does support claimant's allegation that she was not promoted during the more than 17 years she worked for the employer. Although the employer was justified in not promoting claimant based on her low production, we conclude that such a factor would be stressful given the long years she was in her job. We further conclude, however, that claimant has failed to show that such a condition is not generally inherent in every working situation.

In conclusion, because claimant has failed to show that real and objectively stressful events, not otherwise excluded, were the major cause of an alleged mental disorder, we find that claimant failed to prove a compensable claim under ORS 656.802. We therefore affirm the Referee's upholding of the self-insured employer's denial.

ORDER

The Referee's order dated February 28, 1991 is affirmed.

January 31, 1992 Cite as 44 Van Natta 185 (1992)

In the Matter of the Compensation of
LINDA L. WALLACE, Claimant
WCB Case No. 91-01972
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Davis' order which dismissed this matter for lack of jurisdiction. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSION AND OPINION

The Referee dismissed this matter, because he concluded he did not have jurisdiction over whether claimant had exceeded the number of attending physicians allowed by choice.

Claimant raises OAR 436-10-060(3) which provides in pertinent part that if a worker is required to change physicians due to changes in the definition of attending physician caused by the 1990 amendments to the Workers' Compensation Law, this change of physicians will not count in the calculation of the number of choices of attending physician to which a worker is entitled.

The Referee concluded that, although this rule is relevant in deciding the merits of the substantive issue in contention between the parties, it nonetheless does not vest jurisdiction over this matter in the Board or its Hearings Division. We agree.

Subsequent to the date of the Referee's order we issued our order in Tracy Johnson, 43 Van Natta 2546 (1991). In Johnson, we held that a dispute involving a worker's request for a third change of attending physician is, by definition, not a "matter concerning a claim" over which the Hearings Division has jurisdiction. Accordingly, the referee in Johnson lacked jurisdiction over the issue of whether claimant had exceeded the number of physicians allowed by choice.

We conclude that in the instant case the Referee likewise lacked jurisdiction to consider the issue of whether claimant had exceeded the allowed number of attending physicians.

ORDER

The Referee's order dated May 23, 1991 is affirmed.

In the Matter of the Compensation of
ROGER H. WARNER, Claimant
WCB Case No. 89-18731
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that increased claimant's unscheduled permanent disability award for a low back injury from 12 percent (38.4 degrees), as awarded by a Determination Order, to 14 percent (44.8 degrees). On review, the issue is extent of unscheduled permanent disability. We conclude that the Hearings Division lacked jurisdiction over this matter and vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant's aggravation claim was closed pursuant to a July 20, 1990 Notice of Closure, which declined to award claimant any additional permanent disability

in excess of that which had been awarded by a prior Determination Order. The Notice of Closure found claimant medically stationary as of July 3, 1990.

CONCLUSIONS OF LAW AND OPINION

Under the current version of ORS 656.268(4)(e) and OAR 436-30-050, a worker who objects to a Notice of Closure must first request reconsideration by the Appellate Unit of the Department of Insurance and Finance. Upon receipt of a request, the Appellate Unit conducts a reconsideration proceeding and issues an order. Only after the Appellate Unit has issued a reconsideration order may the worker request a hearing with the Board under ORS 656.283. See ORS 656.268(6)(b); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

In this case, claimant's low back condition became medically stationary on July 3, 1990. Accordingly, the mandatory reconsideration procedures set forth in ORS 656.268 apply to this claim. See Or Laws 1990 (Special Session), ch. 2, 54(3); Betty R. Young, 44 Van Natta 47 (1992). Rather than requesting reconsideration of the SAIF Corporation's Notice of Closure, however, claimant requested a hearing with the Board. Clearly, by operation of ORS 656.268(4)(e), claimant's request for hearing was null and void as a matter of law. See Lorna D. Hilderbrand, supra. Therefore, we conclude that the Hearings Division was without authority to hold a hearing.on this matter and vacate.

ORDER

The Referee's order dated March 20, 1991 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

January 31, 1992 Cite as 44 Van Natta 187 (1992)

In the Matter of the Compensation of
ROBERTA J. WILSON, Claimant
WCB Case No. 90-15449
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

The insurer requests review of Referee Knapp's order that: (1) set aside the denials of claimant's neck, shoulder and left and right arm conditions; and (2) set aside the insurer's Notice of Closure. On review, the issues are compensability and premature closure. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS," with the exception of the last paragraph on page 3 and with the following supplementation. Claimant began treating with Dr. Long, M.D., on July 26, 1990. He released claimant to regular work on July 30, 1990.

FINDINGS OF ULTIMATE FACT

Claimant's work activity was the major contributing cause of the onset of her shoulder, neck, and arm conditions. These conditions were established by medical evidence supported by objective findings.

Claimant was medically stationary at the time of claim closure.

Claimant has sustained a 5 percent loss of the use and function of her left arm. She has also sustained a 5 percent loss of earning capacity as a result of her left shoulder condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's upper left extremity condition was compensable under the relevant occupational disease statutes as amended by Oregon Laws 1990 (Special Session), chapter 2. See ORS 656.802(1)(c) and (2). We affirm, with the following comment.

The insurer argues that there was no objective evidence, i.e., no physically verifiable impairment, to substantiate claimant's neck, shoulder and arm conditions. We have previously held that objective evidence includes not only physically verifiable impairment, but may also be based on the physician's evaluation by means of a physical examination in conjunction with the worker's description of the pain she is experiencing. See Suzanne Robertson, 43 Van Natta 1505, 1507 (1991).

Claimant's initial complaints involved the left arm, hand, wrist, shoulder, neck, and occasional right hand numbness. (Exs. 1, 3, 4, 9, 11 and 21-2). After her carpal tunnel surgery, claimant continued to complain of pain in the left shoulder and neck, with radiation down the left arm. Dr. Franks, neurosurgeon, observed claimant's expression of pain on cervical rotation and indicated he was able to document periscapular discomfort. (Exs. 16, 19).

Dr. Rosenbaum, neurologist, who performed an independent medical examination, recorded claimant's complaints. Far from contending that the complaints were imaginary, he opined that claimant's symptoms were most likely reflective of cervical strain. (Ex. 21-3). Based on claimant's reported chronic left arm and forearm pain with minor numbness in the left hand, Dr. Long, M.D., diagnosed a cumulative trauma disorder involving the upper extremities, left greater than right. (Ex. 26). These medical evaluations of claimant's complaints are sufficient objective evidence to substantiate claimant's neck, arm and shoulder conditions. Suzanne Robertson, supra.

Premature Closure

The Referee also concluded that the insurer prematurely closed claimant's claim. We disagree.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation savings clause contained in Section 54(2) does not apply. However, the matter at issue here, claim closure under ORS 656.268(4), is subject to a special exception to the Act's general applicability provision, which exempts claims that became medically stationary prior to July 1, 1990. See 54(3). The insurer declared claimant medically stationary on June 5, 1990. We accordingly analyze this matter under ORS 656.268 prior to its amendment. See former ORS 656.268(3) (now renumbered ORS 656.268(4)).

It is claimant's burden to establish that she was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or 622, 625, rev den 303 Or 590 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). We accordingly evaluate claimant's condition and the reasonable expectation of improvement as of the July 11, 1990

On review, claimant's attorney contends that he is entitled to a carrier-paid attorney fee under amended ORS 656.386(1) because he was instrumental in obtaining SAIF's acceptance of claimant's aggravation claim without a hearing. In claimant's original hearing, the Referee had considered the issue of whether an assessed fee was authorized under that provision. Relying on our decision in Duane L. Jones, 42 Van Natta 875 (1990), the Referee concluded that claimant's counsel was not entitled to an assessed fee because SAIF voluntarily accepted the aggravation claim prior to hearing and no hearing was held on the matter.

Since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow a carrier-paid fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases, such as this case, in which the order was not final on or before the effective date of the act. SB 540 3.

We conclude that claimant's counsel was instrumental in obtaining compensation for claimant's aggravation claim without a hearing. SAIF denied claimant's aggravation claim on August 3 and September 12, 1989. (Exs. 12-8 and 12-9). Claimant's attorney requested a hearing on each denial and solicited information supporting the claim from Dr. King. (See Ex. 8). SAIF subsequently rescinded its denial and accepted claimant's aggravation claim. (See Ex. 10). Because claimant's counsel was instrumental in obtaining compensation for claimant without a hearing, a carrier-paid attorney fee for services prior to the hearing is warranted. ORS 656.386(1); Richter v. Pacific Auto Body & Paint, 108 Or App 470 (1991); on remand Ernest C. Richter, 44 Van Natta 101 (1992); on recon 44 Van Natta 118 (1992).

Claimant also requests an assessed fee for his counsel's services at hearing and on Board review in securing a carrier-paid attorney fee. We disagree. Because attorney fees do not constitute compensation, claimant would not be entitled to an attorney fee award for services rendered before the Referee and Board for "finally prevailing" after remand on this issue. See ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 1314 (1991); Ernest C. Richter, supra.

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 pre-hearing rescission of SAIF's denial is $1,050, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of services), the complexity of the issue and the value of the interest involved.

Accordingly, that portion of the Referee's original order which awarded claimant's attorney a $1,050 fee is modified. Rather than being payable from claimant's compensation, as previously granted by the Referee, the $1,050 attorney fee is payable by SAIF in addition to claimant's compensation. Therefore, in the event that claimant's attorney has already received the $1,050 fee from claimant's compensation, SAIF shall pay claimant the $1,050 as reimbursement for the fee.

ORDER

The Referee's order dated March 5, 1991, as corrected March 14, 1991, is modified. Claimant's counsel is awarded an assessed attorney fee for services rendered prior to hearing concerning SAIF's acceptance of claimant's aggravation claim in the amount of $1,050, to be paid by the SAIF Corporation. In the event that claimant's attorney has already received a $1,050 fee from claimant's compensation, SAIF shall pay claimant the $1,050 as reimbursement for the fee.

In the Matter of the Compensation of
LESLIE THOMAS, Claimant
WCB Case No. 91-01224
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Spangler's order which: (1) found that the insurer had untimely raised the issue that claimant's head injury claim was barred as untimely filed; (2) alternatively, found that the insurer had not established that it was prejudiced by the allegedly late filing; and (3) set aside the insurer's denial of claimant's head injury claim. On review, the issues are hearing procedure, timeliness, and compensability.

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

The Referee concluded that the insurer did not properly raise the issue of timeliness. We agree.

Relying on Glory Yankauskas, 43 Van Natta 670 (1991), the insurer argues that the timeliness issue was properly before the Referee for consideration. We conclude that Glory Yankauskas, 43 Van Natta 670 (1991) is distinguishable from the present case. In Glory Yankauskas, supra, we held that an insurer had not waived any defense as to late filing of the claim, although the issue was not raised until claimant rested her case at hearing. We based our conclusion on the fact that the insurer properly raised the issue of failure to give notice at the first hearing and that claimant did not request a continuance indicating a need for additional time to prepare for the issue. Id.

In the present case, the issue of claimant's allegedly late filing was not raised until after all the evidence had been submitted, both parties had rested their case and the record had been closed except for subsequent unrecorded closing arguments. Not until the insurer had commenced its closing summation did it raise the issue as a defense. Claimant objected to the insurer's defense as untimely raised.

In Ricardo Aguas, 42 Van Natta 2783 (1990), we held that where a party explicitly stated at the outset of a hearing that it had no cross-issues, and then raised an issue for the first time at closing argument over the other party's objection, the new issue had not been properly raised. Further, we have consistently held that we will not consider an issue raised for the first time during closing argument. John C. Schilthuis, 43 Van Natta 1396, 1399 (1991); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989). In accordance with the aforementioned holdings, we conclude that the insurer's contention that the claim was time-barred was not properly raised at hearing.

In the alternative, even if the insurer had properly raised the issue of claimant's allegedly late claim filing, the insurer has not proven actual prejudice by failure to receive timely notice insofar as passage of time alone is not sufficient to meet the insurer's burden of proof. Argonaut Ins. Co. v. Mock, 95 Or App 1, rev den 308 Or 79 (1989).

Late filing of notice may be excused if the insurer has not been prejudiced by failure to receive timely notice. The insurer has the burden of proving prejudice. Inkley v. Forest Fiber Products Co., 288 Or 337, 348 (1980); Ford v. SAIF, 71 Or App 825, 831, rev den 299 Or 118 (1985); Satterfield v.

Compensation Dept., 1 Or App 524, 529 (1970). Specifically, the insurer must prove actual prejudice which occurred after expiration of the 30-day notice period. Grimes v. SAIF, 87 Or App 597, 601 (1987); Ford v. SAIF, supra, 71 Or App at 828; McNett v. Roy-Ladd Const. Co., 46 Or App 601, 605, rev den 289 Or 588 (1980).

Here, the insurer contends that had the employer known of claimant's injury in a timely manner, it could have required claimant to be examined by a doctor to determine whether any injury had occurred. However, since claimant's hematoma condition may not have been apparent simultaneously with his head injury, we are not persuaded that an earlier investigation of the accident would have yielded any more relevant information than was ultimately uncovered. Accordingly, we conclude that the insurer has failed to sustain its burden of proving actual prejudice.

Finally, the insurer contends that claimant is required to prove that his July 1990 head injury was the major contributing cause of his hematoma, pursuant to ORS 656.005(7)(a)(A), and because his hematoma constitutes a "consequential condition." We disagree.

Claimant's hematoma condition is properly characterized as a primary consequence of the July 1990 injury. The medical evidence is consistent with claimant's testimony that he began experiencing headache symptoms shortly after the accident. Those symptoms continued to plague claimant, prompting him to seek treatment from Dr. Newby, surgeon. The medical evidence therefore demonstrates that claimant's current condition arose from the July 1990 accident, as opposed to being a "consequence" of the injuries that he sustained in the accident. Jeff A. Newman, 43 Van Natta 2709, 2710 (1991); also see Julie K. Gasperino, 43 Van Natta 1151 (1991).

Consequently, claimant must prove that the July 1990 accident was a material contributing cause of his current condition in order for his claim to be compensable. After conducting our review, we agree with the Referee that claimant has satisfied this burden of proof.

Inasmuch as the insurer has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. 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 assessed fee for claimant's counsel's services on review is $1000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 23, 1991 is affirmed. For services on Board review, claimant's attorney is awarded $1000, to be paid by the insurer.

In the Matter of the Compensation of
ELMER L. BREWSTER, Claimant
WCB Case No. 90-18849
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Spangler's order which denied claimant's request for payment of permanent total disability benefits from November 14, 1989 through July 2, 1990 pending the self-insured employer's appeal of a previous referee's July 3, 1990 order. On review, the issue is stay of payment pending appeal. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant requested a hearing on October 1, 1990, contending that the employer had failed to comply with the previous referee's July 3, 1990 order and seeking penalties and attorney fees.

CONCLUSIONS OF LAW AND OPINION

In both the February 6, 1991 order and the February 20, 1991 order on reconsideration, the Referee defined the issue as a request to determine the correct effective date of claimant's permanent total disability award. The Referee declined to address that issue because it had been decided by a previous referee and was pending Board review. Therefore, he found that he was without authority to decide the merits of the correct effective date and declined to order the employer to pay permanent total disability benefits before July 3, 1990.

Claimant contends that the issue is whether the retrospective portion of the permanent total disability award, as determined by the previous referee, should be paid pending the employer's appeal of that award. We agree that this is an accurate statement of the issue at hearing and on review.

In support of his argument, claimant relies on Section 54(2) of Oregon Laws 1990 (Special Session) and concludes that the former version of ORS 656.313 was applicable since claimant's hearing request which resulted in the earlier referee's July 3, 1990 order was filed before May 1, 1990 and the hearing was convened before July 1, 1990. However, we disagree that either Section 54(2) or former ORS 656.313 is applicable here.

Section 54(2) provides:

> "Any matter regarding a claim which is in litigation before the Hearings Division, the Board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990."

We have recently held, under substantially similar facts, that the issue of whether payment of compensation is stayed pending an insurer's appeal and penalties and attorney fees cannot be considered the same "matter regarding a claim" as the substantive issue of compensability previously in litigation. Raymond J. Seebach, 43 Van Natta 2687 (1991); Gary R. LaChance, Sr., 43 Van Natta 2746 (1991). Here, the issues presented to Referee Spangler of whether payment of compensation is stayed pending appeal did not arise until issuance of

the previous referee's July 3, 1990 order on extent of disability. Therefore, the issue of the employer's conduct pending its appeal was not before the previous referee. Claimant's request for hearing on the issue of stayed compensation pending the employer's appeal was not filed until October 1, 1990, and the hearing was not convened until January 22, 1991. Thus, we find that the litigation "savings clause" does not apply. Raymond J. Seebach, supra.

Further, the matter at issue here is not subject to a special exception to the act's general applicability provision. See e.g. Section 54(3). Moreover, neither party contends that application of the 1990 amendments will produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, this case is properly analyzed under the Workers' Compensation Act as amended, effective July 1, 1990.

As amended, ORS 656.313((1)(a)(B) provides that the compensation appealed is stayed except for "[p]ermanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed." Consequently, pending the review process, the employer was entitled to stay payment of permanent total disability compensation through July 2, 1990, the day before the issuance of the earlier referee's order appealed by the employer. ORS 656.313(1)(a)(B). Here, the employer has paid permanent total disability benefits commencing July 3, 1990. Accordingly, we affirm the Referee's ultimate holding and note that, pending appeal, the employer was not obligated to pay claimant's permanent total disability compensation before July 3, 1990.

ORDER

The Referee's order dated February 6, 1991, as reconsidered February 20, 1991, is affirmed.

February 6, 1992 Cite as 44 Van Natta 203 (1992)

In the Matter of the Compensation of
WILMA L. EMERICH, Claimant
WCB Case No. 90-06377
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of that portion of Referee Holtan's order that directed it to pay claimant's additional 8 percent (12 degrees) scheduled permanent disability award for a right leg (knee) injury at the rate of $305 per degree. Claimant cross-requests review of those portions of the Referee's order that: (1) affirmed a Determination Order awarding claimant no unscheduled disability for a mental condition; (2) increased claimant's scheduled permanent disability award for loss of use or function of the right leg (knee) from 16 percent (24 degrees), as awarded by Determination Order, to 24 percent (36 degrees); and (3) affirmed a Determination Order awarding claimant 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the left leg (knee). On review, the issues are extent of scheduled and unscheduled permanent disability and the rate of scheduled permanent disability.

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

On review, claimant contends that because the standards omit an impairment value for chondromalacia, this in and of itself is proof by "clear and convincing" evidence that the degree of permanent scheduled disability suffered by claimant is more than the entitlement indicated by the standards. Therefore, claimant seeks an additional award of 12 to 16 percent permanent disability for each leg (knee). See former ORS 656.283(7) and 656.295(5)

We do not find that the diagnosis of chondromalacia alone is sufficient to meet the legal test for clear and convincing evidence, and thus establish that claimant's disability is greater than that indicated by application of the standards. See Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390 (1987). The criteria for rating scheduled disability is the permanent loss of use or loss of functioning of the injured member. Former ORS 656.214(2); see, e.g. former OAR 436-35-010, 220 and 230. While a diagnosis identifies the potentially impairing condition, it does not measure the permanent loss of use or functioning of the injured member that results. We find, as did the Referee, that when viewed as a whole, this record does not establish that it is "highly probable" that the degree of permanent scheduled disability claimant suffers is more than the entitlement indicated by the standards. Riley Hill General Contractor, Inc., supra at 402.

Claimant did not prevail on her cross-request for review. Nevertheless, claimant's attorney is entitled to an assessed attorney fee for defending against SAIF's request for review regarding the rate of scheduled permanent disability. See 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 rate of scheduled disability issue is $400, 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 21, 1991 is affirmed. For services on review, concerning the rate of scheduled permanent disability issue, claimant's counsel is awarded a reasonable assessed fee of $400, payable by the SAIF Corporation.

In the Matter of the Compensation of
JUDY R. HICKS, Claimant
WCB Case No. 90-22539
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Black's order that upheld the insurer's denial of her headaches and musculoligamentous injuries sustained in an October 1989 motor vehicle collision while returning home from physical therapy for a compensable September 1989 injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact" as supplemented.

Claimant filed her request for hearing on December 27, 1990; the hearing was held on March 20, 1991.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt the Referee's reasoning and conclusions with the following comment.

The Referee concluded that, because claimant's request for hearing was filed after May 1, 1990, and the hearing was convened after July 1, 1990, the Workers' Compensation Act as amended effective July 1, 1990 applies. We agree. See Ida M. Walker, 43 Van Natta 1402 (1991).

It is undisputed that claimant's injuries arose not from the compensable September 1989 industrial accident, but rather as a consequence of an October 1989 motor vehicle collision while returning home from physical therapy for the compensable condition. In Julie K. Gasperino, 43 Van Natta 1151 (1991), which issued subsequent to the Referee's order, we held that the "major contributing cause" standard required by ORS 656.005(7)(a)(A) applies to "secondarily consequential conditions." As claimant's original industrial injury was not the major contributing cause of her consequential headaches and musculoligamentous conditions, her claim is not compensable.

ORDER

The Referee's order dated April 30, 1991 is affirmed.

February 6, 1992 Cite as 44 Van Natta 205 (1992)

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
ORDER OF ABATEMENT
Craine & Love, Claimant Attorneys
Pamela Schultz, Defense Attorney

Claimant requests reconsideration of our January 29, 1992 Order On Review (Remanding).

In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn. The insurer is requested to file a response to the motion within ten days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

February 6, 1992 Cite as 44 Van Natta 205 (1992)

In the Matter of the Compensation of
JAMES R. ROLANDSON, Claimant
WCB Case No. 90-15493
ORDER ON REVIEW
David O. Horne, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Lipton's order which set aside its denial of claimant's head injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked as a clerk at a convenience store. On January 21, 1990, claimant was transported to Providence Hospital by ambulance with a head wound. The hospital record states that "witness report apparent seizure" but that "[claimant] doesn't remember events." (Ex. 1). The doctor who treated claimant at the hospital diagnosed a seizure disorder. (Ex. 3).

Claimant has a history of seizures. Prior to January 1990, he last experienced a seizure in 1987. (Ex. 3A). Claimant's drivers' license was suspended due to his medical condition. (Ex. 3B).

On January 22, 1990, claimant submitted an 801 form stating that he was "walking from back room to front and possibly slipped or tripped." (Ex. 2).

Due to his concern that the January 21 incident could interfere with regaining his drivers' license, see Ex. C, claimant submitted two statements to the Department of Motor Vehicles (DMV), both undated. One statement was from James French and reported that, on January 21, 1990, he observed a large white male leaving the convenience store "in an agitated state." (Ex. A). The report further stated that, when he walked into the store, French saw claimant lying on the floor. The other statement was from a co-worker, Mark Buloze. The report stated that he entered the store and saw a young large male standing over claimant "with an object in his hand" and that the person "was visibly upset." (Ex. B). Neither French nor Buloze testified at the hearing.

Claimant also submitted two medical reports to the DMV. Dr. Lorts, M.D., Medical Director of the Emergency Services Department at Providence Hospital, reported that, "upon further review and description of the incident by both witnesses and [claimant] himself, he may have been assaulted by an unknown individual[.]" (Ex. 2B-1). The report concluded that, "[a]lthough one cannot be positive, it does appear that there is significant information supporting [claimant's] contention that he probably did not have a seizure and consequently should not have his drivers[']' license suspended." (Id. at 2). A report from Dr. Gardner, M.D., diagnosed claimant with "past seizure disorder, possibly alcohol related." (Ex. 3A).

Claimant subsequently was terminated from his job at the convenience store for stealing.

CONCLUSIONS OF LAW AND OPINION

The Referee, in finding the claim to be compensable, did not make any findings regarding claimant's credibility. We therefore make our own credibility findings based on the substance of the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). We find that claimant is not credible. His accounts of the events of January 21, 1990 are not consistent. Claimant testified at hearing that, while in the back room, he heard a customer come in, and then walked to the front and acknowledged the customer. (Tr. 16). Claimant stated that he "went back to straighten some things on the shelf until [the customer] was ready to make his purchase." (Id.). After that, he only remembers being questioned by the ambulance crew. (Id.).

The emergency treatment record, however, states that claimant could not remember what happened, but notes that "witness report apparent seizure." (Ex. 1). To the area manager, claimant reported that he blacked out while walking down an aisle and may have hit his head on a shelf. (Tr. 29). Claimant specifically denied being assaulted by anyone. (Id). Moreover, the next day,

claimant filed the 801 form reporting that he "possibly slipped or tripped" while walking from the back room. (Ex. 2).

Having found him not to be credible, we give no weight to claimant's testimony regarding how his head was injured. Furthermore, we give little weight to the statements signed by James French and Mark Buloze. They are undated, unsubstantiated statements from persons who did not testify at hearing.

In determining how claimant was injured, the remaining evidence in the record consists of Dr. Hoppock's diagnosis of "seizure disorder" and Dr. Lorts' opinion that claimant "probably did not have a seizure." We find Hoppock's opinion to be the more reliable evidence. Dr. Lorts did not actually treat claimant, but based his conclusion on claimant's own account and the statements from French and Buloze, all of which we have given little or no weight. We therefore conclude that claimant failed to prove that his work was a material contributing cause of his head injury.

ORDER

The Referee's order dated May 6, 1991 is reversed. The insurer's denial of May 30, 1990 is reinstated and upheld.

In the Matter of the Compensation of
COLLEEN D. STETSON, Claimant
WCB Case No. 89-09899
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Fink's order that: (1) upheld the insurer's partial denial of her claim for her neck, shoulder and upper back condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial and unreasonable resistance to the payment of compensation. The insurer cross-requests review of those portions of the Referee's order that: (1) found a "de facto" denial of claimant's right carpal tunnel syndrome; and (2) assessed penalties and attorney fees for allegedly unreasonable claims processing of the "de facto" denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last paragraph in that section. We add the following supplementation.

At times, Dr L. P. Gambee diagnosed claimant as suffering from carpal tunnel. (Ex. 3). Other times, Dr. Gambee diagnosed claimant's condition as tendinitis. (Ex. 5B). The insurer accepted claimants wrist complaints relying upon Dr. Gambee's tendinitis claim. (Ex. 6). The insurer's acceptance of the claim based upon the tendinitis diagnosis was not a "de facto" denial of a claim for carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law in effect prior to the 1990 amendments to the Workers' Compensation Act. We agree that, because claimant requested a hearing before May 1, 1990 and a hearing was convened prior to July 1, 1990, the law in effect prior to the 1990 amendments is applicable. Or Laws 1990 (Special Session), ch. 2, 54(2)

Compensability/neck, shoulder and upper back condition

The Referee found that claimant's work activity was not a material contributing cause of her neck, shoulder and upper back condition. On review, claimant contends that her conditions were not diagnosed by her original treating doctors because the doctors' charts were incomplete. Claimant argues that the Referee should have relied upon the opinions of Drs. Nichols and Bussanich, who treated claimant for her neck, shoulder and back condition.

The insurer contends that the two physicians who initially treated claimant (Dr. M. Gambee and Dr. L.P. Gambee) diagnosed only tendinitis and possible carpal tunnel syndrome involving her right hand, wrist and arm. The insurer argues that, it was not until claimant began treating with chiropractors that her condition was also diagnosed to include acute severe upper thoracic and lower cervical sprain/strain, right shoulder strain, right arm brachial neuralgia, right arm extensor and flexor muscle myalgia and tendinitis and radiculopathy.

It is not entirely clear whether claimant's claim is based on an occupational disease theory or an industrial injury theory. Regardless of which theory, we agree with the Referee that claimant has not established that either her work activity or the accepted injury was a material contributing cause, or the major cause, of her neck, shoulder and back condition. Claimant's 801 Form reported that she had pain in her hand through use of a tool at work. The emergency room report describes claimant's condition as a sore wrist.

The chart notes of claimant's first two treating doctors, Drs. M. Gambee and L.P. Gambee, do not include mention of neck, shoulder or back complaints. Additionally, in his report, Dr. Nye, M.D., did not mention any symptoms or complaints by claimant in regard to her neck, shoulder or back. Finally, both Dr. Nye and Dr. L.P. Gambee have reported that chiropractic treatment is inappropriate for a carpal tunnel syndrome and Dr. Gambee disagreed with the diagnosis of a neck condition. Dr. Gambee reiterated that, in his opinion, claimant's condition consisted of mild carpal tunnel and tendinitis of the thumb.

We are not persuaded by claimant's argument that the physicians' reports should be discounted because of the minor omissions or discrepancies noted in claimant's brief. Finally, as pointed out by the Referee, because claimant did not appear at hearing, he was unable to make a credibility finding to support her argument that she had experienced the neck, shoulder and back condition symptoms regardless of the fact that three doctors did not document such symptoms. Under the circumstances, we affirm the Referee on the issue of compensability of claimant's neck, shoulder and back condition.

Penalties and attorney fees/unreasonable and untimely denial

Claimant argues that, even if the denial is upheld and there are no amounts "then due," the insurer's denial was unreasonable and a penalty may be assessed. Claimant argues that the denial was unreasonable as it was based solely upon the opinion of Dr. Gambee, who, claimant has argued, is unreliable. In addition, claimant contends that the insurer unreasonably resisted the

payment of compensation as it failed to accept or deny the May 3, 1989 claim until its denial issued on July 21, 1989, which was over sixty days after the claim was made. ORS 656.262(10).

We agree that there are no amounts due upon which to base a penalty. Moreover, we have above concluded that claimant's neck, shoulder and back condition is not compensable. Accordingly, as the claim is not compensable, there can be no unreasonable resistance to the payment of compensation. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). Therefore, claimant is not entitled to a penalty and related fee.

"De facto" denial/carpal tunnel syndrome

The Referee concluded that the insurer had notice of claimant's carpal tunnel syndrome by April 27, 1989; however, the condition was neither accepted nor denied until the date of hearing. The Referee assessed a penalty and attorney fee for the insurer's failure to process claimant's carpal tunnel syndrome claim. The Referee also awarded an assessed fee for claimant's counsel's services in overcoming the "de facto" denial.

On review, the insurer contends that, at hearing, claimant's counsel indicated that he was not raising the "de facto" denial as an issue, if the insurer would accept carpal tunnel as part of claimant's claim. The insurer argues that there is no evidence of a failure to respond to any bill or claim for disability related to carpal tunnel syndrome and nothing was in a "de facto" denied status.

We agree with the insurer. At hearing, claimant's counsel stated that the issues were the July 21, 1989 denial and "kind of a 'de facto' denial." He stated that claimant's accepted condition was right wrist tendinitis, however, the medical records indicated carpal tunnel or overuse syndrome. Claimant's counsel stated that, if the carrier was accepting an overuse or a carpal tunnel syndrome, "end of discussion." He further stated that if the insurer did not accept the condition, then he would raise the "de facto" denial of those conditions. Tr. 4. Counsel for the insurer responded by stating that claimant's nerve conduction studies were paid for and the carpal tunnel syndrome was an accepted part of the claim. Tr. 5, 6.

We conclude that the insurer merely clarified the accepted condition at hearing, and there was neither a "de facto" denial of claimant's carpal tunnel condition nor a withdrawal of such a denial at hearing.

Penalties and attorney fees/"de facto" denial

As we have concluded that there was no "de facto" denial of claimant's carpal tunnel condition, we reverse the Referee's award of a penalty and related attorney fee for an unreasonable denial. We also reverse the Referee's assessed attorney fee award for claimant's counsel's services in overcoming a "de facto" denial.

ORDER

The Referee's order dated March 19, 1991 is reversed in part and affirmed in part. That portion of the Referee's order that assessed penalties and attorney fees for an unreasonable "de facto" denial of claimant's carpal tunnel syndrome is reversed. The Referee's assessed attorney fee of $2,000 for claimant's counsel's services in overcoming a "de facto" denial of a carpal tunnel syndrome is also reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ROBERT E. WOLFORD, Claimant
WCB Case No. 91-00232
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Baker's order which dismissed this matter for lack of jurisdiction. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's hearing request because he concluded he lacked jurisdiction. The Referee found that a request to the Director for reclassification of the claim from nondisabling to disabling and a reasonable time for the Director to issue his decision are prerequisites to the Referee's having jurisdiction over this matter which concerns the correctness of the insurer's initial classification of claimant's claim as nondisabling. We agree.

Subsequent to the date of the Referee's order we issued our decision in Christine A. Degrauw, 44 Van Natta 91 (1992). In Degrauw, we held that we did not have jurisdiction over a decision that a worker's initial claim was nondisabling until she has first exhausted the administrative remedy contained in 1990 Or Laws (Special Session), ch. 2, 48(3)(c).

Section 48(3) provides, in pertinent part:

> "A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:
>
> " * * * *
>
> "(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon . . . ."

Furthermore, amended ORS 656.268(11) states that upon receipt of a request made pursuant to section 48 quoted above, the Department of Insurance and Finance "shall determine whether the claim is disabling or nondisabling," and that "a copy of such determination shall be mailed to all interested parties . . ." Accordingly, we conclude that we do not have jurisdiction until claimant first exhausts this administrative remedy.

ORDER

The Referee's order dated April 24, 1991 is affirmed.

In the Matter of the Compensation of
THOMAS E. EDISON, Claimant
WCB Case No. 90-12890
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Westerband, Gunn, Moller, Neidig and Kinsley.

The SAIF Corporation requests review of those portions of Referee Tenenbaum's order that: (1) found that claimant had timely filed his claim; and (2) set aside its denial of claimant's claim for a stroke. Claimant cross-requests review of that portion of the Referee's order which awarded his counsel $2,700 for services at hearing. On review, the issues are timeliness, compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee concluded that claimant's claim was timely filed. We agree.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Former ORS 656.262(8) provided that a worker could request a hearing on a denial at any time within 60 days after the mailing of the notice of denial. In conjunction with this section, ORS 656.319(1)(a) provided that with respect to a denied claim, a hearing shall not be granted nor shall a claim be enforceable unless a request for hearing is filed not later than the 60th day after the claimant was notified of the denial.

The potential conflict between former ORS 656.262, referring to "mailing" as the critical event, and the reference in ORS 656.319 to a claimant being "notified", was resolved by the Supreme Court in Norton v. Compensation Dept., 252 Or 75 (1968). In Norton, the Court held that "notification", as that term was used in ORS 656.319, occurred upon mailing of the denial. The court noted that actual knowledge of the denial would also be a reasonable interpretation of "notification;" however, the court chose mailing because it determined that it also was a reasonable interpretation and would permit harmonization of the conflicting statutes. Id. at 78.

In July 1990, the legislature amended ORS 656.262(8) by removing the language "on the denial at any time within 60 days after the mailing of the notice of denial" and adding the language, "pursuant to ORS 656.319." Therefore, ORS 656.262(8) now states:

> "If an insurer or any other duly authorized agent of the employer for such purpose, on record with the Director of the Department of Insurance and Finance denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be be given to claimant. A copy of the notice of denial shall be mailed to the director and to the employer by the insurer. The worker may request a hearing pursuant to ORS 656.319."

OR Laws 1990 (Special Session), ch. 2, 15. ORS 656.319(1)(a) was left unchanged by the legislature.

Claimant contends that by removing the language in ORS 656.262(8) which refers to mailing a denial, the legislature has substituted notice of a denial as the critical event which starts the 60-day time period running. We agree.

By removing the language that led to the conflict between ORS 656.262 and ORS 656.319, the statutes now clearly indicate that the 60-day period does not begin with mailing of the denial, but rather with notice of the denial to claimant.

Legislative history supports this interpretation and reflects that the legislature was aware that the change in ORS 656.262(8) would impact the interpretation of ORS 656.319(1)(a), causing notice of the denial to become the critical event. (Hearings of the Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, side A.) The Committee indicated that the intent of the amended language was that notice would be deemed given when the notice was delivered to the worker. Id. While it is not clear that the legislature understood how ORS 656.262 and 656.319 might be interpreted if the worker refused to allow delivery of notice by certified mail, it is clear that the legislature intended receipt of notice to serve as the critical triggering event.

In summary, we conclude that the 60-day time period does not begin running until the worker is notified of the denial. We further conclude that in this context, "notified" means actual notice or proof that the worker had constructive knowledge of the denial, such as by refusing delivery of a certified letter from the insurer or self-insured employer or receipt of the certified letter by someone on claimant's behalf at the correct address.

Turning to the present case, claimant received notice of the denial on April 17, 1990. Inasmuch as the actual 60th day fell on Saturday, June 16, 1990, the 60th day for purposes of ORS 656.319 is Monday, June 18, 1990, the day on which claimant filed his request for hearing. Accordingly, claimant's request for hearing was timely.

Compensability

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

Attorney Fees/Hearing

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the Referee's award of $2,700 for services concerning SAIF's denial is a reasonable amount for claimant's counsel's services rendered at hearing. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the timeliness and compensability issues is $1,200, to be paid by the SAIF Corporation. 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 January 17, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, payable by the SAIF Corporation.

Board Chair Neidig and Board Member Kinsley, specially concurring.

We agree that the amendment to ORS 656.262(8) mandates the result reached by the majority. We write to express our concern over the economic impact this decision will have on insurers and self-insured employers.

Prior to this decision, the date a denial was mailed was the critical event which started the running of the 60-day time period. Therefore, an insurer or self-insured employer could mail the denial using the regular mail. However, as the majority decision indicates, it now appears that a denial must be mailed by certified mail in order for an insurer or self-insured employer to be certain that claimant has received notice of the denial. The increased postage and labor costs that an insurer or self-insured employer will incur as a result of the use of certified mail will be substantial. The long-range effect will be to increase the cost of providing compensation for injured workers.

Although the legislative history does support the majority's conclusion, it does not appear that the legislature considered the financial impact of the amendment to ORS 656.262(8). The major goal of Senate Bill 1197 was to reduce the cost of providing workers' compensation benefits. However, the change to ORS 656.262(8), as the we have interpreted it, has the opposite effect. The resulting increased postage and labor costs will ultimately be passed on and could result in increased premiums to employers in this state.

February 7, 1992 Cite as 44 Van Natta 213 (1992)

In the Matter of the Compensation of
SHARRON L. NOLLEY, Claimant
WCB Case Nos. 90-20251 & 90-08081
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Robert Jackson (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Brazeau's order that: (1) found that claimant's condition was medically stationary March 7, 1990 and that her claim was not prematurely closed; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for a low back condition; (3) upheld United Employers' denial of claimant's aggravation claim for the same condition; and (4) affirmed

a Determination Order award of 15 percent (48 degrees) unscheduled permanent partial disability. On review, the issues are premature closure, compensability, aggravation and extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following exception: All references in the Opinion and Order to United Pacific Insurance Company are replaced with references to United Employers Insurance Company.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that claimant's cervical and lumbar strain was medically stationary March 7, 1990 and that her claim was not prematurely closed. We agree.

A claim for compensation shall not be closed nor temporary disability benefits compensation terminated if the worker's condition has not become medically stationary. ORS 656.268(1). The test for determining whether a worker is medically stationary is whether "further medical improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary when her low back injury claim was closed. ORS 656.266; Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

Claimant contends that she was not medically stationary on March 7, 1990, because an MRI at that time revealed small disc herniations in the cervical and lumbar spines. However, Dr. Bernstein, the treating physician, noted the herniations on the same day he concluded that claimant was medically stationary, indicating that they were nonclinical and not necessarily consistent with claimant's symptoms. He did not relate the herniations to claimant's compensable injury. Moreover, Dr. Dickerman, M.D., explained that protruding discs exist in the general population, with or without trauma, and that claimant's herniations may be a normal finding unrelated to any injury. He also noted that claimant had no radicular symptoms normally associated with such findings and opined that the bulges were insignificant.

After our review of the record, we conclude that there is insufficient evidence to establish that claimant's disc herniations are causally related to her compensable injury. Accordingly, as noted by the Referee, whether further medical improvement of that condition was reasonably expected is not relevant to a determination of whether her compensable condition was medically stationary. See Ray Graves, 42 Van Natta 2425 (1990). On this record, we conclude that claimant has failed to establish that she was not medically stationary when her low back injury claim was closed.

Aggravation

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

Compensability

The Referee concluded that claimant had failed to establish that she sustained a compensable new injury while employed as a pizza delivery driver for SAIF's insured. The Referee first concluded that claimant had failed to establish legal causation, noting that there was no persuasive evidence that she sustained an injury within the course and scope of her employment. He also

concluded that, even if claimant had injured herself at work, she had failed to establish that the alleged injury was the major contributing cause of her disability or need for medical treatment.

We agree with the Referee's conclusion regarding legal causation. As the Referee observed, the record is almost devoid of any medical evidence that an injury or worsening occurred during her second period of employment. We do not agree, however, with the Referee's application of the major contributing cause standard in this case. The Referee evidently relied upon ORS 656.005(7)(a)(B), which provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or 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." Or Laws 1990 (Special Session), ch. 2, 3.

Subsequent to the Referee's order, we issued Bahman M. Nazari, 43 Van Natta 2368 (1991), in which we held that ORS 656.005(7)(a)(B) does not determine compensability of the initial injury, but rather limits a carrier's liability for continuing disability or need for medical services. Accordingly, in order to establish an initial compensable injury, claimant only has to prove that the work was a material contributing cause of her condition. See also Mark N. Wiedle, 43 Van Natta 855 (1991).

Nonetheless, even under the material contributing cause standard, we agree with the Referee's alternative conclusion that claimant has failed to establish medical causation. Claimant began working at SAIF's insured during April 25, 1990. On two subsequent occasions, however, she failed to tell her doctors that she had returned to work, let alone that she had sustained a new injury. During a September 28, 1991 independent medical examination, claimant admitted that she had been working as a pizza delivery driver at the time of the earlier examinations, but had no explanation why she did not provide the information. In any event, those examiners concluded that the driving had no apparent effect on claimant's condition. The only evidence to the contrary is a question and answer narrative from Dr. Caughran, who agreed that claimant's work as a pizza delivery driver worsened her underlying condition. That opinion, however, consists simply of an affirmative response to a question posed by claimant's counsel and is unaccompanied by any reasoning. Accordingly, we do not find it persuasive. Somers v. SAIF, 77 Or App 259 (1986).

After our review of this record, we conclude that claimant has failed to establish that her work at SAIF's insured was a material contributing cause to her disability or need for treatment. Accordingly, we affirm the Referee's decision to uphold SAIF's denial.

Extent of Permanent Disability

We adopt that portion of the Referee's order that concluded that claimant has failed to establish permanent impairment as a result of her compensable injury.

ORDER

The Referee's order dated February 28, 1991 is affirmed.

In the Matter of the Compensation of
DUANE A. ALIOTH, Claimant
WCB Case No. 90-02636
ORDER ON REVIEW
Sherwood & Coon, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Borchers' order that upheld the self-insured employer's denial of his occupational disease claim for a bilateral hand condition. On review, the issues are res judicata and, if the claim is not barred, compensability.

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

We agree with the Referee's reasoning and conclusion that the claim is barred by res judicata, because claimant's condition has not changed since the prior unappealed denial. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989). However, we also note that claimant is not precluded from proving any contribution his employment may have had to a worsening or development of his bilateral hand condition subsequent to the 1988 denial. See Anna M. Turner, 41 Van Natta 1956 (1989); see also Howard W. Lankin, 35 Van Natta 849 (1983), aff'd mem 69 Or App 53, rev den 298 Or 470 (1984) (Uncontested denial of heart condition does not bar future litigation of job-related worsening of that condition).

Assuming that claimant's condition had changed since the 1988 denial, we would reach the following alternative conclusion.

Claimant concedes and we agree that, because his condition is not compensable as of the 1988 denial, the current claim is properly characterized as a claim for a worsening of a preexisting noncompensable condition. See Anna M. Turner, supra. Therefore, pursuant to Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985), and Weller v. Union Carbide Corp., 288 Or 27, 35 (1979), claimant bears the burden of proving a pathological worsening of his preexisting condition. See Hollister L. Starr, 39 Van Natta 79, 80-81 (1987).

The only medical evidence which arguably supports a finding of such a worsening is the opinion of Dr. Nolan, who examined claimant once. Nolan stated: "Certainly any exposure to impact tools after January 1988 would have worsened [claimant's] condition." (Ex. 28-3). Inasmuch as Nolan's opinion is speculative, it is not persuasive. See Gormley v. SAIF, 52 Or App 1055 (1981).

After our de novo review, we conclude that claimant has not established a pathological worsening since the 1988 denial. Consequently, he has not carried his burden of proof.

ORDER

The Referee's order dated February 15, 1991 is affirmed.

In the Matter of the Compensation of
VIRGINIA L. BAKER, Claimant
WCB Case No. 91-03134
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee Brown's order that set aside its denial of claimant's right arm injury claim. In the alternative, the employer asks that, in order to remedy the Referee's alleged failure to act as an impartial Referee and conduct a fair hearing, the Board remand this case to the Hearings Division for a new hearing. We interpret the employer's request for a new hearing to be a motion for a change of Referee. On review, the issues are compensability and change of Referee. We deny the motion, and affirm.

FINDINGS OF FACT

We defer to the Referee's demeanor credibility finding as it concerns claimant, and adopt his credibility finding as it concerns Mr. Hager.

On February 18, 1991, claimant, a 56-year-old raimann operator, felt a tight pinch in her right forearm when she attempted to remove a patched sheet of veneer from her machine and place it onto the conveyor belt. She tried to continue working, but when the pain recurred with activity, she reported to her supervisor, completed an 801 form, and went to the emergency room as directed.

Claimant was examined at the emergency room by Dr. Showerman. He noted tenderness over the right forearm up to the elbow, some limitation of range of motion, and pain on forced supination. He diagnosed an acute strain of the right forearm extensor muscles, and prescribed a sling, ice, and Naprosyn, a prescription anti-inflammatory pain killer.

Ten days later, claimant was seen by independent examining physician Dr. Helman. He noted some tenderness of the right lateral epicondyle and tenderness to the soft tissues of the pronator and extensor mechanism, and diagnosed an overuse injury to the right forearm.

Claimant currently is treating with osteopathic physician Dr. Aaronson. He has documented tenderness of the right lateral epicondyle, inability to fully pronate the right arm, and painful lateral flexion.

On March 12, 1991, the employer denied claimant's right arm condition, whether diagnosed as a strain or overuse syndrome, as not supported by objective findings. Claimant filed a request for hearing on March 12, 1991; the hearing was held on June 3, 1991.

At hearing, the employer's attorney called claimant's supervisor, Mr. Hager, as a witness. After direct examination, cross-examination, and finally re-direct examination by employer's attorney, employer's attorney announced he had no further questions of Mr. Hager. Claimant's attorney likewise had no further questions of the witness. After both attorneys had completed their examinations, the Referee examined Mr. Hager. The Referee then allowed the attorneys to again examine the witness. At hearing, the employer's attorney did not object to the Referee's examination of Mr. Hager nor request a new hearing.

FINDINGS OF ULTIMATE FACT

Claimant has established by objective evidence that her February 1991 injury is a material contributing cause of her right forearm condition and need for treatment.

The hearing was conducted in a manner that achieved substantial justice.

CONCLUSIONS OF LAW AND OPINION

Motion for New Hearing

On review, the employer alleges that the Referee improperly injected himself into the proceeding as an advocate for claimant. Therefore, it seeks a new hearing to develop a fair record. We conclude the request is neither timely nor in accordance with OAR 438-06-095.

In support of its allegation of partiality, the employer asserts that after cross-examination of Mr. Hager by claimant's attorney, the Referee began his own cross-examination of the witness before re-direct examination by the employer's attorney. Thus, it argues, the Referee concluded that he did not believe the witness before all the evidence from that witness had been received, thereby precluding the employer from effectively conducting any re-direct examination or rehabilitation of the witness.

The record does not substantiate the employer's allegation of partiality. To the contrary, the hearing transcript demonstrates that the employer had every opportunity to proceed with further examination of the witness in question. For whatever reason, the employer chose not to avail himself of this opportunity following the Referee's questions. In any event, we find nothing in the record to suggest that the hearing was conducted in any manner other than one which would achieve substantial justice. ORS 656.283(7).

Furthermore, the employer has not complied with OAR 438-06-095. If the employer thought the Referee was biased, it should have objected at hearing and requested a change of Referee. OAR 438-06-095(2). This request was neither promptly nor diligently filed. See OAR 438-06-095(3).

For the aforementioned reasons, the employer's request for a new hearing is denied.

Compensability

Turning to the merits of the case, we affirm the Referee's conclusion that claimant has established by objective medical evidence that her injury was a material contributing cause of her right arm disability and need for treatment. However, we offer the following analysis.

On review, the employer argues that claimant has failed to prove that the claim is established by medical evidence supported by objective findings, as required by ORS 656.005(7)(a). We disagree. "Objective findings" in support of medical evidence are defined to include, but are not limited to, "ranges of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence substantiated by clinical findings." Amended ORS 656.005(19).

Dr. Showerman, the emergency room physician who examined claimant immediately after her injury, noted tenderness over claimant's right forearm up to the elbow, some limitation of range of motion, with pain on forced supination. Based on claimant's reporting to him of the mechanics of injury and his physical examination of claimant, Dr. Showerman concluded that claimant had sustained an

acute strain of the right forearm extensor muscles. Thereafter, he prescribed a sling, ice, and Naprosyn, a prescription anti-inflammatory pain killer. Moreover, independent examining physician Dr. Helman and osteopathic physician Dr. Aaronson have examined claimant and reported similar findings. A physician's evaluation of a worker's subjective complaints satisfies the definition of "objective findings." Suzanne Robertson, 43 Van Natta 1505 (1991).

Consequently, we find claimant has established by objective medical evidence that her injury was a material contributing cause of her right forearm disability and need for medical treatment.

For successfully defending on review against the employer's request for review, claimant's counsel is entitled to an assessed attorney fee. 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 Board review is $700, 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated June 3, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed attorney fee of $700, payable by the self-insured employer.

February 11, 1992 Cite as 44 Van Natta 219 (1992)

In the Matter of the Compensation of
LAWRENCE R. BOCK (Deceased), Claimant
WCB Case Nos. 91-01298 & 91-01154
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The beneficiary of the deceased claimant requests review of Referee Podnar's order that: (1) declined to require the SAIF Corporation to pay claimant's beneficiary survivor benefits pursuant to an earlier referee's order; and (2) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable failure to pay the aforementioned benefits pending Board review of the earlier referee's order. On review, the issues are stay of compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings," with the following supplementation. The prior referee's order, which set aside SAIF's denial and ordered that the beneficiaries' claim be processed according to law, was affirmed by a October 29, 1991 Order on Review as reconsidered by a November 26, 1991 order.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions." See e.g. Raymond J. Seebach, 43 Van Natta 2687 (1991). We add the following supplementation.

Pursuant to amended ORS 656.313, filing of a request for Board review by an insurer "stays payment of the compensation appealed, except for [certain express exceptions not applicable here.]" (Emphasis supplied). In turn, ORS 656.005(8) defines "compensation" to include "all benefits * * * provided for a compensable injury to a subject worker or the worker's beneficiaries * * *." SAIF's stay of payment of benefits was proper under amended ORS 656.313.

ORDER

The Referee's order dated May 3, 1991 is affirmed.

February 11, 1992 Cite as 44 Van Natta 220 (1992)

In the Matter of the Compensation of
CORDY A. BRICKEY, Claimant
Own Motion No. 66-0302M
AMENDED OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On January 14, 1992, we issued an Own Motion Order in which we denied SAIF's request for reimbursement of a narrative report it sought regarding the compensability of claimant's claim. We reasoned that a medical report to determine compensability is not compensation as defined by ORS 656.005(8) and, thus, could not qualify as reimbursable compensation payable to injured workers under ORS 656.625.

We have reconsidered our reasoning in light of Brooks v. D & R Timber, 55 Or App 688 (1982), in which the Court of Appeals held that diagnostic medical services are considered compensable when the services are reasonable and necessary in order to determine whether a causal relationship exists between a compensable condition and a current condition. The Board has followed this holding in several subsequent cases, e.g., Katherin J. Hunter, 43 Van Natta 1488 (1991), Kenneth M. Simons, 41 Van Natta 378 (1989) and Clifford D. Howerton, 38 Van Natta 1425 (1986). This policy encourages the insurer to fully investigate and, therefore, properly process the claim. Although Brooks was not an own motion case, we believe that it is appropriate to apply this policy to claims that are in own motion status. We, therefore, find that a medical report is an integral part of a medical service provided to an injured worker and, as such, would qualify as compensation under ORS 656.005(8) and ORS 656.625. In light of the reasoning set forth herein, we withdraw our disavowal of Henry J. Dolinar, issued January 17, 1991 (unpublished).

Accordingly, we find that the requested medical services are reasonable and necessary and are justified by special circumstances. Therefore, we withdraw our January 14, 1992 order and authorize SAIF's request for reimbursement for a narrative report in the amount of $35.00.

As amended herein, we adhere to and republish our January 14, 1992 order. The parties' rights to reconsideration and appeal shall run from the date of this order.

In the Matter of the Compensation of
ALEX J. COMO, Claimant
WCB Case No. 90-16139
ORDER ON REVIEW
Kevin Mannix, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant, pro se, requests review of Referee Crumme's order that affirmed a Determination Order award of 5 percent (6.75 degrees) scheduled permanent disability for loss of use of the left foot and 37 percent (118.4 degrees) unscheduled permanent disability for a cervical and lumbar back injury. On review, claimant presents additional evidence. We treat such as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). The issues on review are remand, extent of unscheduled permanent partial disability, and extent of scheduled permanent partial disability. We deny the request for remand and modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. Claimant's lumbar surgery was performed on March 31, 1989.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee affirmed the May 15, 1990 Determination Order and dismissed claimant's hearing request. No party requested that the request be dismissed. Moreover, we are aware of no other authority supporting a dismissal, absent such a request. Therefore, we reinstate claimant's hearing request and proceed to the merits.

Remand

On November 18, 1991, claimant submitted to the Board an unsigned, partial copy of a report dated March 12, 1991. Claimant contends that this partial report establishes that he is totally disabled. We treat this submission as a motion to remand for the taking of further evidence. Judy A. Britton, supra. We deny the motion.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

We find that the record is not insufficiently developed without the partial report submitted by claimant on review. The record includes a report from Medical Consultants Northwest which details the extent of claimant's permanent disability. Dr. Smith, attending surgeon, concurred with this report. Further evidence on extent of disability would be cumulative. Furthermore, the document claimant submits addresses his condition more than two months after hearing. Therefore, this document is not materially relevant to the extent of claimant's disability at the time of hearing. See Gettman v. SAIF, 289 Or 609 (1980). Accordingly, we conclude that the record has not been improperly, incompletely or otherwise insufficiently developed and deny claimant's motion to remand this case for admission of further evidence. Mark A. Ostermiller, 42 Van Natta 2873 (1990).

Extent of Unscheduled Permanent Partial Disability

The Referee affirmed the Determination Order award of 37 percent unscheduled permanent partial disability for cervical and lumbar spine injuries. We modify.

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; WCD Admin. Order 1-1989.

The parties do not dispute the Referee's values for age (1), formal education (0), training (0), and skills (1). Thus, the total age value is 1, and the total education value is 1.

Adaptability

We adopt the Referee reasoning and conclusion on the issue of adaptability with the following supplementation.

The insurer argues that the Referee incorrectly classified claimant's at-injury job as "heavy." We agree with the Referee. When claimant was injured, he was carrying a microwave weighing approximately 80 pounds. Therefore, his at-injury job involved heavy work. See Douglas P. Evans, 43 Van Natta 337 (1991). Claimant's work selling restoration auto parts involves light/medium work. Thus, we find that claimant has an adaptability factor of 2.5. Former OAR 436-35-310(3).

Impairment

We adopt the Referee's reasoning and conclusions regarding the values for cervical impairment (2.92 percent) and anal impairment (0).

We note that, under the applicable law, we rate disability as of the date of hearing, not as of the date of claim closure. The amendments to ORS 656.283(7) and 656.295(5), which create a different rating principle, do not apply because claimant became medically stationary before July 1, 1990. See Or Laws 1990, Ch. 2, Sec. 54(3); Stephen A. Roberts, 43 Van Natta 1815 (1991).

The Referee relied on the range of motion measurements taken by the Medical Consultants Northwest, Inc. on November 11, 1989. (Ex. 30). The insurer argues that, given the usual deference to a treating physician, the earlier measurements of Dr. Smith, attending surgeon, should be used.

ORS 656.245(3)(b)(B) provides, in pertinent part, that "[e]xcept as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." Thus, the clear language of the statute as applied to the present case means that, although the disability is rated at the time of hearing, the attending physician at the time of claim closure provides the findings regarding the worker's impairment. See Dennis E. Conner, 43 Van Natta 2799 (1991).

Thus, as attending surgeon at claim closure, Dr. Smith must make the findings regarding claimant's impairment. Dr. Smith fulfilled this requirement by concurring with the Consultants' report and thereby adopting their more recent range of motion measurements. (Ex. 32). Dennis E. Conner, supra. Furthermore,

as noted above, the rating of disability is to be done as of the hearing and the Consultants' report is closest to the hearing date. Therefore, we use the Consultants' measurements, as adopted by Dr. Smith, to determine claimant's loss of range of motion.

Claimant's loss of lumbar range of motion is rated as follows: flexion (6 percent), extension (2 percent), right lateral flexion (2 percent), left lateral flexion (3.6 percent). Former OAR 436-35-360. These values are added for a total loss of lumbar range of motion of 13.6 percent. Former OAR 436-35-360(10).

Dr. Smith found that claimant's chronic lumbar condition limited the repetitive use of his back in that he must avoid excessive lifting, bending, and twisting, and prolonged sitting and standing. (Ex. 27-2). This impairment is rated at 5 percent. Former OAR 436-35-320(4).

Claimant's compensable lumbar surgery involved six facetectomies, each valued at 3 percent. (Ex. 21-2); former OAR 436-35-350(2). These multiple surgery values are combined, not added, for a value of 16.7 percent. Roger F. Slade, 43 Van Natta 631 (1991).

The multiple residuals in the lumbar spine are combined, not added, for a total lumbar impairment of 31.6 percent. Former OAR 436-35-360(11). This value is combined with the cervical impairment of 2.92 percent for a total impairment of the spine of 33.6 percent. Id.

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 2.5, the product is 5. When that value is added to claimant's impairment value 33.6, the result is 38.6 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, 39 percent.

Extent of Scheduled Permanent Partial Disability

We adopt the Referee's reasoning and conclusion regarding the issue of the extent of scheduled permanent partial disability.

ORDER

Claimant's hearing request is reinstated. The Referee's order dated February 6, 1991 is modified. In addition to the 37 percent (118.4 degrees) awarded by the Determination Order, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, giving him a total award to date of 39 percent (124.8 degrees) unscheduled permanent disability for a cervical and lumbar spine injury. The remainder of the order is affirmed.

In the Matter of the Compensation of
CARL HIGHT, Claimant
Own Motion No. 66-0306M
AMENDED OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On January 14, 1992, we issued an Own Motion Order in which we denied SAIF's request for reimbursement of a narrative report it sought from Dr. Bert regarding the compensability of claimant's current claim. We reasoned that a medical report to determine compensability is not compensation as defined by ORS 656.005(8) and, thus, could not qualify as reimbursable compensation payable to injured workers under ORS 656.625.

We have reconsidered our reasoning in light of Brooks v. D & R Timber, 55 Or App 688 (1982), in which the Court of Appeals held that diagnostic medical services are considered compensable when the services are reasonable and necessary in order to determine whether a causal relationship exists between a compensable condition and a current condition. The Board has followed this holding in several subsequent cases, e.g., Katherin J. Hunter, 43 Van Natta 1488 (1991), Kenneth M. Simons, 41 Van Natta 378 (1989) and Clifford D. Howerton, 38 Van Natta 1425 (1986). This policy encourages the insurer to fully investigate and, therefore, properly process the claim. Although Brooks was not an own motion case, we believe that it is appropriate to apply this policy to claims that are in own motion status. We, therefore, find that a medical report is an integral part of a medical service provided to an injured worker and, as such, would qualify as compensation under ORS 656.005(8) and ORS 656.625.

Accordingly, we find that the requested medical services are reasonable and necessary and are justified by special circumstances. Therefore, we authorize SAIF's request for reimbursement for a narrative report in the amount of $5.50.

We consequently withdraw our January 14, 1992 order. As amended herein, we adhere to and republish our January 14, 1992 order. The parties' rights to reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KEVIN S. KELLER, Claimant
WCB Case No. 90-07466
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members en banc.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) set aside its denial of claimant's claim for a psychological condition; and (2) set aside the March 23, 1990 Determination Order as premature. Claimant cross-requests review of that portion of the order that upheld the employer's denial of claimant's medical services claim for a work hardening program. In the event that the Determination Order is reinstated, the employer seeks a reduction of permanent partial and temporary total disability awarded claimant. On review, the issues are compensability, premature closure, medical services, extent of permanent partial disability and temporary total disability. We affirm in part and vacate in part.

FINDINGS OF FACT

Claimant compensably injured his low back in November 1987, while pulling lumber on a green chain for the employer. He sought treatment from Dr. Griffith, a chiropractor, who diagnosed a lumbar strain and provided conservative treatment. Claimant returned to regular work in December 1987, and sought no further treatment until December 1988, when he consulted Dr. Watts, a chiropractor, for increased back pain. Dr. Watts provided treatment until March 15, 1988, at which time claimant was found to be medically stationary and released from care.

Claimant compensably injured his right leg and low back on January 17, 1989, while working as a quality control technician for the employer. He returned to Dr. Watts, who diagnosed traumatically induced acute low back strain. Dr. Watts later released claimant to return to modified work on January 25, 1989, and ultimately released him to regular work on February 13, 1989.

On March 7, 1989, claimant began treating with Dr. Robertson, an orthopedic surgeon, who noted that claimant was still symptomatic and recommended that he be given modified work with no heavy lifting. After a bone scan proved normal, Dr. Robertson released claimant to regular work without restrictions on April 28, 1989, and later declared claimant medically stationary on May 19, 1989.

Claimant returned to full-time work as a forklift operator for the employer. Thereafter, claimant returned to Dr. Robertson on several occasions complaining that his back had been aggravated by driving the forklift. Dr. Robertson recommended that claimant return for physical therapy, but believed that he could continue to perform regular work.

Claimant continued full-time work driving a forklift until the employer's mill closed on July 26, 1989. Claimant did not immediately look for work and continued to seek treatment from Dr. Robertson for low back pain. Dr. Robertson continued to treat claimant with physical therapy and recommended vocational assistance and a work hardening program.

Claimant was examined by Dr. Rosenbaum, a neurosurgeon, on November 6, 1989. Dr. Rosenbaum diagnosed a chronic lumbosacral strain and believed that

claimant was medically stationary. Based on claimant's subjective complaints, Rosenbaum did not believe that claimant could return to his work at injury.

In February 1990, Dr. Robertson reported that significant psychological factors were preventing claimant's recovery and recommended a psychological evaluation.

A Determination Order issued March 23, 1990, declaring claimant medically stationary on December 4, 1989, and awarding benefits for periods of temporary disability and 12 percent unscheduled permanent partial disability.

In April 1990, claimant began treating with Dr. Tempest, M.D. After examination, Dr. Tempest agreed with Dr. Robertson that claimant would benefit from a structured work hardening program and referred claimant to Dr. Henderson, a psychiatrist, for psychological evaluation. Dr. Henderson diagnosed depression related to claimant's January 1989 back injury.

At the employer's request, claimant was examined by Dr. Parvaresh, a psychiatrist, in June 1990. Dr. Parvaresh concluded that claimant suffered no psychological condition as a result of his industrial injury and believed that claimant's condition would improve if he could find work within his capabilities.

On July 11, 1990, the employer issued three separate denials. The first denied claimant's request for treatment at the Injured Workers Program at Sacred Heart General Hospital and asserted that the treatment was not reasonable and necessary. The second denied claimant's request for vocational services, on the basis that claimant could return to regular work. The third denied claimant's claim for a psychiatric condition.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

On May 7, 1990, the Governor signed into law Senate Bill 1197, a comprehensive revision of the workers' compensation law. Or Laws 1990 (Special Session), ch. 2. The hearing in this case was convened after July 1, 1990. Therefore, the "savings clause" contained in section 54(2) does not apply. In addition, the matters at issue concerning compensability and medical services are not subject to a special exception to the Act's general applicability provision. See, e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze those matters under the Workers' Compensation Act as amended, effective July 1, 1990.

With regard to the extent of claimant's permanent disability, however, we note that the amendments to ORS 656.214(5) and ORS 656.268(4) through (8) do not apply, because claimant was not medically stationary after July 1, 1990. See Or Laws 1990 (Special Session), ch. 2, 54(3).

Compensability

The Referee concluded that claimant had established the compensability of his psychological condition. We agree with the Referee's conclusion, but offer the following analysis.

As amended, ORS 656.005(7)(a) provides, in part:

> "A 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

We have previously construed that revised provision as retaining the traditional definition of a compensable injury and, accordingly, held that, as in the past, an injured worker establishes an initial injury claim by proving that a work related accident was a material contributing cause of disability or need for treatment. See Mark Wiedle, 43 Van Natta 855 (1991). We also have recognized, however, that by virtue of subsection (A), a worker who allegedly suffers an injury or disease as a secondary consequence of an original compensable incident will be compensated for that alleged condition only if the compensable injury is the major contributing cause of that consequential condition. See Julie K. Gasperino, 43 Van Natta 1151 (1991).

In this case, claimant seeks compensation for a psychological condition he alleges to have arisen from the compensable low back injury he sustained in January 1989. As such, claimant has the burden of proving, by a preponderance of the evidence, that his January 1989 low back injury is the major contributing cause of his psychological condition.

The parties submitted two expert opinions on medical causation. Claimant relies on the opinion of Dr. Henderson, who concluded that the 1989 industrial injury played the major contributing role in claimant's psychiatric disorder. The employer relies on the opinion of Dr. Parvaresh, who concluded that claimant's psychiatric problems were longstanding and not amenable to psychiatric intervention.

When there is a dispute between medical experts, we give more weight to those opinions that are both well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). After our review of the record, we find that only Dr. Henderson's opinion meets both criteria and, accordingly, find it most persuasive. We give little weight to the opinion of Dr. Parvaresh, because it is not as well reasoned. Dr. Parvaresh acknowledged that claimant has a diagnosable psychiatric disorder, but attributes all of claimant's psychiatric problems to a preexisting condition. There is no evidence, however, that claimant had any psychological problems or treatment prior to his compensable injury. To the contrary, claimant was functioning well prior to injury and sought marriage counseling only after ensuing back pain had, among other things, interfered with his sexual functioning.

In contrast, Dr. Henderson's opinion is thorough and well reasoned. He persuasively relates claimant's psychological symptoms to the chronic pain and vocational dislocation resulting from claimant's compensable injury. He also reported that claimant's original need for marriage counseling was in large part due to the complications resulting from his back injury. That conclusion is consistent with the testimony of claimant and his wife, as well as the notes of the marriage counselor, Susan Schloss.

We conclude that claimant has shown, by a preponderance of the evidence, that his January 1989 low back injury is the major contributing cause of his

psychological condition. Accordingly, we affirm that portion of the Referee's order that set aside the employer's denial.

Premature Closure

In light of our decision that claimant's psychological condition is compensable, and because it is undisputed that the psychological condition was not medically stationary at the time of claim closure, we affirm and adopt the Referee's conclusion that the March 23, 1990 Determination Order prematurely closed claimant's claim. ORS 656.268(1).

Medical Services

The Referee concluded that the requested work hardening program was not a compensable medical service under ORS 656.245 and, therefore, upheld the employer's denial. We conclude that the Referee lacked jurisdiction to consider the matter and vacate that portion of his order.

Pursuant to ORS 656.704(3), the Board's authority to conduct hearings is limited to "matters concerning a claim," which do not include any dispute regarding medical treatment for which a resolution procedure is otherwise provided in ORS Chapter 656. In this regard, ORS 656.327 provides, in part:

> "(1)(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer, self-insured employer shall so notify the parties and the director."

We recently held that ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of [administrative] rules." Stanley Meyers, 43 Van Natta 2643 (1991). Therefore, original jurisdiction over disputes regarding the necessity or reasonableness of medical services now lies exclusively with the Director. Id.

As in Stanley Meyers, supra, the employer here has denied payment for the work hardening program on the basis that it is not medically necessary for the treatment of claimant's compensable injury. From the foregoing, it follows that original jurisdiction over this dispute lies with the Director. Accordingly, by operation of ORS 656.704(3) and 656.327(1)(c), the employer's denial of the treatment under ORS 656.262 is null and void as a matter of law, and the Referee was without authority to consider the matter.

We reach our decision with knowledge that, at the time this dispute arose, the work hardening program had been proposed but not yet undertaken. We note that ORS 656.327 refers to medical treatment that a claimant "is receiving." However, we do not believe that, by using the term "is receiving," the legislature intended to segregate ORS 656.327 medical services disputes into two classes--one in which the claimant "is receiving" the treatment; the other where claimant had received or is planning to receive the treatment--and have the Director resolve one class and the Board the other. To the contrary, the existing legislative history supports the proposition that the "is receiving" language of ORS 656.327 was intended to extend to prospective medical services. In this regard, a member of the Governor's Workers' Compensation Advisory Committee explained the intent of the amendments as follows:

> "So if there's an issue of excessive, inappropriate or ineffectual medical treatment, the appeal would go to the medical director and the medical director's staff or panel that he wishes to have in his staff would make the decision. The intent with this section is to move from the litigation process with appeals and referees the question of medical treatment being inappropriate, unnecessary or whatever. And decisions then would be made by, again, physicians rather than referees according to the appropriateness of that treatment. An example may be the physician recommends that this worker buy a bicycle for physical therapy and the insurance carrier says no we won't buy the bicycle. Then that would be appealed to the medical director and the medical director's staff under DIF would make the decision whether that was appropriate or not appropriate." Testimony of Ed Redman, Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 75.

Therefore, the precise example set forth in the testimony supports the conclusion that the "is receiving" language of ORS 656.327 should be broadly interpreted to include prospective services. In addition, a restrictive interpretation of the term "is receiving" would not further the stated purpose of the 1990 amendments: to remove from the litigation process questions concerning the reasonableness and necessity of medical treatment and to allow such decisions to be made by a physician. Moreover, such an interpretation would result in an artificial bifurcation of jurisdiction which would unnecessarily complicate the resolution of such matters. We also note that our interpretation is consistent with that of the Director, who has promulgated proposed OAR 436-10-046(1), which provides:

> "If a worker or insurer believes that the worker has received, is receiving, or has been proposed to receive medical treatment for a compensable condition that is excessive, inappropriate, ineffective or in violation of the medical rules and wishes review of the treatment by the director, the worker or insurer shall notify the director." (Emphasis supplied.)

Attorney Fee on Board Review

Because the employer initiated the request for review concerning the compensability of claimant's psychological condition and the premature closure of claimant's claim, and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under 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 is $800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to 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 January 28, 1991 is affirmed in part and vacated in part. That portion of the Referee's order that upheld the self-insured employer's denial of a work hardening program is vacated. claimant's request for hearing on that denial is dismissed for lack of jurisdiction. The remainder of the order is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $800, to be paid by the self-insured employer.

Board members Tenenbaum and Kinsley dissenting.

The majority concludes that the Hearings Division lacks jurisdiction to resolve a dispute regarding the reasonableness and necessity of proposed medical treatment. Because that conclusion conflicts with the plain meaning of the statute, we respectfully dissent.

We agree with the majority that "matters concerning a claim," over which the Hearings Division has jurisdiction, do not include any proceeding for resolving a medical treatment dispute for which another procedure is provided in ORS Chapter 656. See ORS 656.704(3); Stanley Meyers, 43 Van Natta 2643 (1991); Tracy Johnson, 43 Van Natta 2546 (1991). The issue here is whether a procedure, other than a hearing under ORS 656.283(1), is provided to resolve a dispute regarding the appropriateness of medical treatment that claimant has not yet received.

The majority holds that ORS 656.327 provides such a procedure. We disagree. ORS 656.327 provides:

> "(1)(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer or self-insured employer or director shall so notify the parties and the director." (Emphasis supplied.)

The statute clearly authorizes Director review of only medical treatment that claimant "is receiving." It does not authorize Director review of treatment that has been completed or is only proposed.[1] At the time the dispute arose in this case, the work hardening program had been proposed, and claimant was not receiving the treatment. Therefore, ORS 656.327 does not provide a procedure for resolving this dispute.

Accordingly, because this matter involves a dispute for which a resolution procedure is not otherwise provided, we would conclude that the employer's denial raised a matter concerning a claim, over which the Hearings Division has original jurisdiction. See ORS 656.283(1), 656.704(3). To the extent that Robert L. Trump, 44 Van Natta 3 (1992); James B. Palmer, 43 Van Natta 2803 (1991), Robert D. Cox, 43 Van Natta 2726 (1991) and Gary L. Waldrupe, 43 Van Natta 2705 (1991) hold otherwise, we would disavow those cases.

The majority errs in looking to legislative history to ascertain the intent of the legislature. It is well established that one does not resort to examining legislative history to determine the intent of the legislature where the statutory language is clear on its face. Whipple v. Howser, 291 Or 475 (1981). In this case, the language the legislature voted to use is quite clear: "is receiving" means is receiving; the plain English meaning of those words cannot be massaged to mean "has received" or "wants to receive in the future." It is inappropriate to look behind that clear expression of intent.

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[1] Where the treatment the claimant "is receiving" is part of a course of treatment, some of which has already occurred, but which is ongoing, such as a physical therapy program, a series of injections, or a partially completed work hardening program, we would consider that to be treatment the claimant "is receiving" within the meaning of this statute, and subject to the Director's original jurisdiction.

We appreciate the majority's desire to effectuate the intent of the legislature. But our role is to interpret the laws passed, not to legislate ourselves. If the legislature has not said what it meant, it is for the legislature, not this body, to remedy that situation. Furthermore, while the intent of Mr. Redman and others who worked on what became SB 1197 may be clear, the intent of the legislature on this, as on many other provisions of SB 1197, is difficult to ascertain from the nearly non-existent legislative history which preceded passage of this bill. As members of the workers' compensation community, many of us may believe we know what the legislature intended to achieve in 1990, but if the legislature has not passed the law they meant to pass, we may not presume to do it for them. We would conclude the Referee had jurisdiction to consider the proposed medical treatment issue, as there is no other procedure for resolving that dispute in the workers' compensation scheme.

February 11, 1992 Cite as 44 Van Natta 231 (1992)

In the Matter of the Compensation of
THERESA L. LOOMAS, Claimant
WCB Case No. 90-19025
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant requests review of Referee Baker's order that: (1) upheld the SAIF Corporation's de facto denial of claimant's aggravation claim for a bilateral carpal tunnel syndrome condition; (2) concluded that claimant had failed to establish entitlement to interim compensation pending the acceptance or denial of the aggravation claim; and (3) declined to assess a penalty or an attorney fee for SAIF's allegedly unreasonable denial. On review, the issues are aggravation, interim compensation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's conclusions and reasoning concerning claimant's aggravation claim with the following supplementation.

In support of her claim for a worsened condition, claimant relies on the opinions of Dr. Black, her attending physician, and Dr. Patterson, a neurologist, who both reported that claimant has "recurrent" bilateral carpal tunnel syndrome. However, as SAIF points out, the term "recurrent" does not indicate a worsened condition. In fact, it is defined as "the return of symptoms after a remission." Dorland's Illustrated Medical Dictionary 1334 (25th ed. 1974). Accordingly, those opinions establish only the waxing and waning of her symptoms, which was contemplated by the previous award of compensation.

Claimant also relies on a check-the-box concurrence and a short report from Dr. Black, in which he agreed that claimant had suffered a worsening of her underlying condition or a "worsened problem". Those reports, however, do not indicate whether that worsening had occurred since the last award of compensation. Under the facts in this case, and without further explanation, we do not

consider the reports to be persuasive evidence of a compensable aggravation. Somers v. SAIF, 77 Or App 259 (1986).

Most significantly, the course of events which led to the reports upon which claimant relies had begun prior to the July 18, 1990 stipulation. While her condition may have worsened over the last few years, claimant has not established that her condition has worsened since the July 18, 1990 stipulation which last awarded her compensation.

Interim Compensation

Entitlement to interim compensation in the form of temporary total disability depends on whether, before denial of an aggravation claim, there was "a medically verified inability to work resulting from a compensable worsening supported by objective findings." ORS 656.273(6). In Doris A. Pace, 43 Van Natta 2526 (1991), we construed that language as requiring notice or knowledge of an inability to work as documented in a medical report that constitutes prima facie evidence of a compensable worsening.

In this case, claimant contends that Dr. Black's work release dated August 28, 1990 was sufficient to trigger SAIF's duty to commence payment of interim compensation. That release provides, in full:

> "I have recommended that [claimant] stop her current employment for 60 days [due] to recurrence of CTS." (Ex. 37A).

Although the release notified SAIF of claimant's inability to work, it failed to indicate whether her inability to work was due to a worsening of her condition and contained no recitation of objective findings. See ORS 656.273(1). Moreover, it did not address whether her recurrence of carpal tunnel syndrome was more than the waxing and waning of symptoms contemplated by the last award of compensation. See ORS 656.273(8). Accordingly, because the release was not prima facie evidence of a compensable worsening, the Referee properly held that claimant was not entitled to interim compensation benefits.

Penalties and Attorney Fees

We adopt the conclusions and reasoning concerning claimant's entitlement to penalties and attorney fees as set forth in the Referee's order.

ORDER

The Referee's order dated April 26, 1991 is affirmed.

February 11, 1992 Cite as 44 Van Natta 232 (1992)

In the Matter of the Compensation of
PHILLIP D. MEYER, Claimant
WCB Case No. 90-12624
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Tom Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Otto's order that: (1) upheld the SAIF Corporation's denial of claimant's sinus condition; (2) declined to award an attorney fee for services rendered in obtaining SAIF's

acceptance of claimant's eye condition prior to hearing; and (3) declined to assess penalties and related attorney fees for SAIF's allegedly unreasonable claims processing. On review, the issues are compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the conclusions and reasoning of the Referee on the issue of compensability of claimant's sinus condition supplemented with the following comment.

Subsequent to the Referee's order, we analyzed the definition of compensable injury under amended ORS 656.005(7) and distinguished between conditions that are primary consequences and those that are secondary consequences. We held that the 1990 amendments to ORS 656.005(7) do not affect the standard of compensability, i.e., material cause, for conditions intrinsically related to the underlying compensable event. Julie K. Gasperino, 43 Van Natta 1151 (1991). In this case, the Referee analyzed claimant's sinus condition under a material cause standard and found that it was not compensable. We conclude that the Referee's analysis was correct. Claimant failed to carry his burden. See Shirley L. Brock-Tremain, 43 Van Natta 2530 (1991).

Fee for Services Resulting in Acceptance

Claimant also contends that he is entitled to an assessed attorney fee for services rendered prior to hearing that resulted in SAIF's acceptance of his eye condition before the hearing. The Referee found that claimant's attorney was instrumental in obtaining SAIF's acceptance of the claim. However, relying on Duane L. Jones, 42 Van Natta 875 (1990), the Referee concluded that claimant's attorney was not entitled to an assessed fee. Since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing on the matter is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540 3.

We concur with the Referee that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. We base our conclusion on the fact that claimant's attorney requested a hearing on the matter and solicited medical reports supporting the claim prior to SAIF's acceptance. Because claimant's counsel was instrumental in obtaining compensation for claimant without a hearing, an attorney fee for services prior to the hearing is warranted. ORS 656.386(1).

Unreasonable Claims Processing

Claimant contends that he is entitled to a penalty and related attorney fee for SAIF's allegedly unreasonable processing of his sinus and eye conditions. We adopt the Referee's reasoning that neither penalties nor attorney fees were assessable for SAIF's claim processing concerning claimant's sinus condition.

However, as to the eye condition, the Referee found and SAIF conceded, that SAIF did not accept the claim within 90 days as required by ORS 656.262(6).

The Referee found this late acceptance unreasonable, but did not assess a penalty inasmuch as he determined that there were no "amounts then due." Claimant contends on review that the Referee should have assessed a penalty, because unpaid bills for medical services constitute "amounts then due." In the alternative, he argues that, even if there are no amounts due upon which to base a penalty, he is entitled to an attorney fee under ORS 656.382.

We disagree with claimant that SAIF's failure to pay his medical bills forms a basis for a penalty under ORS 656.262(10). We have previously held in Richard J. Stevenson, 43 Van Natta 1883 (1991) that, when an insurer delays in accepting or denying a claimant's claim and there are no amounts then due, there is no basis for a penalty. See Wacker Siltronic v. Satcher, 103 Or App 513 (1990); Richard J. Stevenson, supra.

On the other hand, ORS 656.382(1) also provides for an assessed attorney fee when an insurer engages in conduct, which constitutes an unreasonable resistance to the payment of compensation, even though there are no amounts then due upon which to base a penalty. See Richard J. Stevenson, supra.

In the present case, SAIF did not respond within 90 days as required by ORS 656.262(6). By failing to timely respond to the claim, it delayed the process and the ultimate resolution as to the compensability issue. We find that its failure to respond to claimant's claim for his eye condition was unreasonable and its nonaction had the effect of delaying benefits which were eventually compensable as a result of SAIF's acceptance of the claim. Therefore, SAIF unreasonably resisted the payment of compensation and an attorney fee pursuant to ORS 656.382(1) is assessed on this basis. See Richard J. Stevenson, supra; Steve Chambers, 42 Van Natta 524 (1990); Cindi A. Cadieux, 41 Van Natta 2259 (1989).

Attorney Fee Award

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 acceptance of the eye condition prior to hearing and SAIF's unreasonable processing of that claim is $2,500, 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.

ORDER

The Referee's order dated April 12, 1991 is affirmed in part and reversed in part. For services concerning SAIF's unreasonable claim processing and the acceptance of claimant's eye condition prior to hearing, claimant's attorney is awarded $2,500, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DARLENE M. WELFL, Claimant
Own Motion No. 87-0685M
OWN MOTION ORDER
Malagon, Moore et al., Claimant Attorneys
Marcia Barton & Thomas E. Ewing (Saif), Defense Attorneys

Claimant requests enforcement of that portion of our November 2, 1989 Own Motion Determination that awarded her permanent total disability (PTD) benefits.

By letter dated June 27, 1990, the SAIF Corporation terminated further payments on the PTD award, explaining that we did not have own motion authority to grant that award.

Claimant's own motion request has been reviewed in tandem with her request for Board review in WCB Case No. 90-14783 and has been considered based on the record developed in that case. In WCB Case No. 90-14783, claimant requested Board review of a Referee's order that declined to enforce the Own Motion Determination for lack of jurisdiction. By Order on Review issued this date, we affirmed the Referee's order.

Claimant contends that, because SAIF did not timely appeal the Own Motion Determination, the PTD award is final, and SAIF must pay those benefits. Citing Independent Paper Stock v. Wincer, 100 Or App 625 (1990), SAIF notes that our own motion authority to award any permanent disability benefits ceased as of January 1, 1988. Therefore, SAIF argues, we were without authority to grant PTD, and it was not required to comply with our order. We agree.

In Glen D. Roles, 43 Van Natta 278 (1991), we held that, when a Referee issues an order concerning a matter over which he lacks jurisdiction, the order is invalid and the insurer is not required to comply with it. That rule applies similarly when we issue an order concerning a matter over which we lack jurisdiction.

Under Wincer, supra, we lacked jurisdiction to award PTD benefits on our own motion authority after January 1, 1988. Accordingly, that portion of our Own Motion Determination was invalid, and SAIF is not required to comply with it. See Glen D. Roles, supra. Claimant's request for own motion relief is denied.

IT IS SO ORDERED.

February 11, 1992 Cite as 44 Van Natta 235 (1992)

In the Matter of the Compensation of
DARLENE M. WELFL, Claimant
WCB Case No. 90-14783
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Marcia Barton & Thomas E. Ewing (Saif), Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Gruber's order that: (1) declined, for lack of jurisdiction, to enforce the Board's November 2, 1989 Own Motion Determination granting her permanent total disability benefits; and (2) declined to assess a penalty and related attorney fee for the SAIF Corporation's allegedly unreasonable refusal to pay compensation. SAIF contends on review that this matter should be remanded to the Referee to determine whether it properly terminated the payment of permanent total disability benefits. On review, the issues are enforcement, remand, and penalties and attorney fees.

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

FINDINGS OF FACT

After claimant's aggravation rights had expired, the Board reopened claimant's 1978 injury claim by Own Motion Order dated December 11, 1987, for

the payment of temporary disability compensation. By Own Motion Determination dated November 2, 1989, the Board closed the claim and awarded claimant permanent total disability benefits.

CONCLUSIONS OF LAW AND OPINION

Because claimant's aggravation rights had expired, the reopening and closure of her claim was properly within our own motion jurisdiction under former ORS 656.278. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). It therefore follows that issues arising from claim closure, including claimant's entitlement to any permanent disability benefits, are also within our own motion jurisdiction. In exercising our own motion jurisdiction, we granted claimant benefits for permanent total disability by Own Motion Determination on November 2, 1989.

We have previously held that the Hearings Division does not have jurisdiction to enforce an order issued pursuant to our own motion authority. Ivan Davis, 40 Van Natta 1752 (1988); David L. Waasdorp, 38 Van Natta 81 (1986). Therefore, we conclude that the Referee lacked jurisdiction to enforce the Own Motion Determination. Rather, the enforcement issue is subject to our exclusive own motion jurisdiction. Because the Referee lacks jurisdiction of this matter, we deny SAIF's motion for remand.

By Own Motion Order issued this date, we declined to enforce the payment of the permanent total disability award on the ground that, because we did not have own motion authority to award permanent disability benefits under ORS 656.278, the award is invalid and unenforceable.

ORDER

The Referee's order dated January 14, 1991, as reconsidered on March 7, 1991, is affirmed. Claimant's hearing request is dismissed for lack of jurisdiction.

February 12, 1992 Cite as 44 Van Natta 236 (1992)

In the Matter of the Compensation of
MARCIA G. ARTAJO, Claimant
WCB Case No. 91-00449
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation (on behalf of Senior and Disabled Services Division (SDSD)) requests review of that portion of Referee Myzak's order which set aside its denial of claimant's "new injury" claim for a neck and shoulder condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF first argues that, under Oregon Laws 1990 (Special Session), chapter 2, section 49(1), responsibility rests with claimant's first employer, Dammasch

Hospital, unless claimant sustained a "new compensable injury involving the same condition" while working at her current job with SDSD.[1] We agree. We have interpreted section 49(1) to mean that, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678, 1680 (1991).

SAIF also argues that ORS 656.005(7)(a)(B) applies for purposes of determining whether claimant sustained a "new compensable injury." Therefore, SAIF contends, responsibility does not shift unless the 1990 injury was the major contributing cause of claimant's current condition. We disagree.

We recently held that ORS 656.005(7)(a)(B) is not applicable in the responsibility context. Rosalie S. Drews, 44 Van Natta 36 (1992). We reasoned that, ORS 656.005(7)(a)(B) only determines compensability of further disability or need for treatment once initial compensability is favorably decided; resolution of such an issue is not relevant to the assignment of responsibility. Therefore, responsibility shifts from the original carrier if the new compensable injury is a material contributing cause of disability or need for treatment. Id. The injury also must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a).

The medical evidence shows that claimant has experienced pain in the shoulders, upper back and neck dating from her 1984 injury. (Ex. 21-1). Claimant saw her treating physician, Dr. Weingarten, on a monthly basis for treatment of these symptoms. (Ex. 21C). In October 1989, Dr. Weingarten referred claimant to Dr. Kappes, a rheumatologist, to assess her condition. Dr. Kappes diagnosed a chronic pain syndrome "that was initially triggered by the [1984] injury but is now perpetuated by factors more obscure, possibly psychosocial in nature or possibly due to frustration at being part of the Workers' Compensation system." (Ex. 21-2).

After the September 1990 slip and fall while employed by SDSD, claimant continued to treat with Dr. Weingarten. He stated that claimant's "injury of 9/19/90 was minor and self-limited" and that she only experienced "some short term increase in symptoms from her previous shoulder injury[.]" (Ex. 26-1). He further reported that he "would consider any symptoms which she continues to have as the result of her prior injuries of March 1987 and/or 1984, rather than a true re-injury." (Id.)

Dr. Woolpert, orthopedic surgeon, saw claimant for an independent medical examination. He agreed with Dr. Weingarten "that the injury of 9/19/90 had [no] more than a temporary exacerbation of [claimant's] ongoing chronic difficulty." (Ex. 30-4). He also reported that, although there was "no question that [claimant] had a new episode of injury occurrence, in respect to her ongoing symptoms this injury caused the same symptoms that she had been having all along to become somewhat greater on a temporary basis." (Id.)

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[1] Section 49(2) of the new law imposes restrictions on a carrier's ability to argue that a claim is the responsibility of another carrier. These restrictions involve notice and joinder requirements. Here, although SAIF is the carrier for both Dammasch Hospital and SDSD, its appearance in this case has been only on behalf of SDSD. SAIF, on behalf of Dammasch Hospital, has not been joined in this claim. However, neither party contends that Dammasch Hospital's absence in this claim is error.

Claimant then was examined on referral by Dr. Long, a rehabilitation specialist. After seeing claimant one time, Long reported that claimant's "symptoms, her disability, and her need for treatment have all increased significantly because of the slip and fall incident of 9/19/90." (Ex. 32-5). He also stated that "the incident of 9/19/90 did cause significant worsening of [claimant's] myofascial condition" and that "her condition has [not] returned to pre-September 1990 status." (Ex. 33).

When medical evidence is divided, we give greater weight to the conclusion of the claimant's treating physician, absent persuasive reasons not to do so. See e.g. Weiland v. SAIF, 64 Or App 810, 814 (1983). The Referee did find persuasive reasons to disregard Dr. Weingarten's opinion, stating that Weingarten failed to "analyze the pre-injury and post-injury symptoms in detail" and that his "report is outdated in light of the subsequent developments, i.e., claimant's time loss authorization beginning in March 1991."

We first note that all of the doctors' reports were prepared before March 1991 and that there is no proof in the record that Weingarten's time loss authorization in March 1991 indicates that his opinion changed regarding the cause of claimant's symptoms. Weingarten has been claimant's treating physician since her 1984 injury. As demonstrated by his reports over the years, he has kept a close watch on her status, at times seeing her on a monthly basis. We conclude that Weingarten is in the best position to evaluate claimant's current condition in comparison to her status before September 1990.

Claimant argues that Dr. Weingarten's opinion is contradictory regarding medical causation because he first states that "the injury of 9/19/90 was a new injury, unrelated to her previous problems" and then states that claimant did not "sustain a new, or a significant exacerbation of her old, shoulder injury[.]" (See Ex. 26-1).

We agree that Weingarten's opinion contains some contradictory language. However, we also agree with the Referee, based upon a reading of the entire report, that Weingarten concluded that the September 1990 incident caused only a temporary exacerbation of her "ongoing chronic difficulty" and that her current symptoms are due to her prior 1987 and 1984 injuries. (See id.)

Dr. Weingarten's opinion is further supported by Dr. Woolpert's report. Woolpert's report does contain some minor errors, such as misspelling Weingarten and dating the slip and fall on September 20, 1990 rather than September 19, 1990. The report, however, was accurate regarding claimant's history and symptoms and, therefore, we find it to be reliable evidence.

In conclusion, we hold that the evidence does not establish that claimant suffered a "new compensable injury," i.e., that the September 1990 slip and fall was a material contributing cause of her current need for treatment. We base this conclusion on the greater weight we give to claimant's treating physician's report, as well as Dr. Woolpert's report, and find that this evidence overcomes the opinion of Dr. Long. Responsibility therefore does not shift to SDSD, claimant's current employer.

ORDER

The Referee's order dated April 30, 1991 is reversed in part. SAIF's December 21, 1990 denial and March 27, 1991 partial denial are reinstated and upheld. The Referee's attorney fee award of $1,750 is reversed.

In the Matter of the Compensation of
KELLY BARFUSS, Claimant
WCB Case No. 91-00739
ORDER ON REVIEW
Daniel Spencer, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Brown's order which set aside its denials of claimant's right hand "needle stick" injury. On review, the issue is compensability.

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

To establish a compensable injury, claimant must present evidence that she sustained an accidental injury arising out of the course and scope of employment requiring medical services or resulting in disability or death, established by medical evidence supported by objective findings. ORS 656.005(7)(a). The insurer contends that claimant's "needle stick" injury was not established by medical evidence supported by objective findings. We disagree

It is uncontested that claimant sustained a puncture wound while performing her work activity as a dental assistant. Claimant notified her employer of the injury, who recommended that claimant consult with Dr. Richards, general practitioner. Based on claimant's description of the incident, Dr. Richards believed that claimant sustained a puncture wound from a needle at work.

Further, the "needle stick" injury required medical services. Dr. Richards ordered laboratory testing. During a later examination, claimant discussed her concerns with Dr. Richards about the "needle stick" injury. Thereafter, Dr. Richards recommended that claimant repeat HIV testing in three months and then again in six months. Finally, Richards gave claimant a "soft recommendation" to avoid pregnancy over the next year. There is no contrary medical evidence. Therefore, we conclude that "claimant had suffered an injury and was entitled to know how badly [she] was hurt and if any treatment was appropriate. "Finch v. Stayton Canning Co., 93 Or App 168, 173 (1988), citing Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987).

In Suzanne Robertson, 43 Van Natta 1505 (1991), we construed "objective findings" to require a determination by a physician, based on an examination of the injured worker, that the worker has a disability or need for medical services. Here, Dr. Richards prescribed medical services for claimant based on Richards' expert analysis of examination findings and claimant's description of her puncture wound. Such evidence meets the definition of "objective findings." Robert E. Leatherman, 43 Van Natta 1677 (1991); also see Stephanie A. Farrell, 43 Van Natta 1837, 1893 (1991); Suzanne Robertson, supra. Accordingly, claimant has established a compensable injury.

Inasmuch as the insurer has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. 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 assessed fee for claimant's counsel's services on review concerning the compensability issue is $850 to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue (as represented by claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated May 10, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $850, to be paid by the insurer.

February 12, 1992 Cite as 44 Van Natta 240 (1992)

In the Matter of the Compensation of
ANTHONY G. FORD, Claimant
WCB Case No. 90-11641
ORDER ON REVIEW
Peter O. Hanson, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members en banc.

The insurer requests review of Referee Menashe's order that: (1) set aside its back-up denial of claimant's aggravation claim for a left wrist condition; and (2) denied its motion to dismiss or postpone the hearing a second time. In his respondent's brief, claimant argues that the 1990 amendments to ORS 656.262(6) overruled Bauman v. SAIF, 295 Or 788 (1983), so that the May 8, 1990 back-up denial was not permissible. On review, the issues are dismissal, postponement, propriety of the back-up denial, and compensability. We affirm.

FINDINGS OF FACT

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

On May 18, 1990, the insurer issued a back-up denial of claimant's claim for a worsened left wrist condition, which it had accepted in July 1986. Claimant requested a hearing from the 1990 denial. The hearing was convened on October 8, 1990. Claimant did not appear, but his counsel was present. The Referee granted a continuance to allow the insurer to obtain tape recordings of claimant's alleged admissions to a claims examiner and to subpoena claimant for cross-examination. The hearing was continued on December 7, 1990. Claimant again did not appear. The insurer's attempts to subpoena claimant had been unsuccessful and no additional evidence was offered.

CONCLUSIONS OF LAW AND OPINION

The insurer requested postponement or dismissal of claimant's hearing request, contending that claimant's absence from hearing deprived it of a fair hearing. The insurer reasons that a cross-examination of claimant would have established that its claim acceptance in 1986 was induced by fraud, thus sustaining its back-up denial under the rule in Bauman v. SAIF, supra.

Claimant responds that the 1990 legislative amendments "repealed" the Bauman rule, such that no denials of previously accepted claims are permitted more than two years after claim acceptance. Therefore, according to claimant, the insurer may not use fraud as a basis for its back-up denial. We disagree with both parties' contentions.

Because we hold herein that a crucial portion of the Bauman rule survived the 1990 legislative amendments, we address that issue at the outset. We then consider the merits of the denial and the insurer's motion.

Propriety of Back-up Denial

Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch. 2, 54(2); Ida Walker, 43 Van Natta 1402 (1991).

The threshold issue is whether an insurer may issue a back-up denial, which denies a previously accepted claim, more than two years after claim acceptance. We conclude that amended ORS 656.262(6) allows such a denial in limited circumstances.

The statutes in effect before the 1990 amendments did not expressly address whether an insurer could deny a previously accepted claim. In Bauman v. SAIF, however, the Court ruled that such denials were prohibited, subject to limited exceptions:

> "If, as in this case, the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity." 295 Or at 794 (Emphasis added).

The Court followed the Bauman rule in Ebbtide Enterprises v. Tucker, 303 Or 459, 467 (1987) ("[W]e hold, following Bauman, that the Workers' Compensation Law precludes [the insurer's] attempt retroactively to deny the July 1983 claim absent a showing of fraud, misrepresentation or other illegal activity.") (Emphasis added). See also Jeld-Wen, Inc. v. McGehee, 72 Or App 12, rev den 299 Or 203 (1985). The continued viability of the Bauman rule under the 1990 amendments is the subject of the current dispute.

Unlike the former version of ORS 656.262(6) that was interpreted in Bauman,[1] the recently amended version of ORS 656.262(6) expressly permits back-up denials:

> "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial."

Thus, an insurer may now issue a back-up denial "at any time up to two years from the date of claim acceptance." Id. Moreover, an insurer need not prove fraud, misrepresentation or other illegal activity in support of its back-up denial. Thus, the Bauman rule is overturned insofar as it prohibited those denials. However, the question remains whether, by amending ORS 656.262(6), the 1990 Legislature also intended to prohibit an insurer from issuing a back-up denial, based on a showing of fraud, misrepresentation or other illegal activity, more than two years after claim acceptance.

"The starting point in every case involving a determination of legislative intent is the language of the statute itself." Whipple v. Howser, 291 Or 475, 479 (1981) (citing Greyhound Corp. v. Mt. Hood Stages, Inc., 437 US 322, 330 (1978)). The statute in this case, ORS 656.262(6), in either its former or

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[1] See Bauman v. SAIF, supra, 295 Or at 792, n.1.

present versions, never expressly permitted the issuance of a back-up denial based on a showing of fraud, misrepresentation or other illegal activity. Therefore, the fact that the 1990 amendments to ORS 656.262(6) do not expressly authorize those denials does not necessarily prove that the legislature intended to forbid them.

We now turn to the legislative history of the 1990 amendments. The Bauman rule is well established and supported by public policy that disfavors fraudulent claims. See ORS 656.990(1) (imposes a prison term and/or fine for intentional misrepresentation regarding a claim for compensation); ORS 656.268(14) (allows insurers an offset against future compensation for prior, fraudulently-obtained benefits). Therefore, we believe there must be clear and unambiguous legislative intent to overturn the rule.

Senator Brenneman of the Joint Interim Special Committee on Workers' Compensation addressed the impact of the amendments on the Bauman rule:

> "What this section of the Bill does is that it reverses the Bauman decision. Under old law, an insurer had 60 days from the claim to accept or deny the claim. Under new law, the insurer now has 90 days. Under the old law, once an insurer accepted a claim, the 60 days elapsed, the decision was final no matter whether or not evidence of fraud or mistake was later discovered. Now the insurer has two years to discover such evidence and issue a retroactive denial." Special Session, Senate Floor Debates, May 7, 1990, Tape 4, Side A.

Although Senator Brenneman stated that Section 15 "reverses" Bauman, he appeared to believe that Bauman prohibited, without exception, the issuance of a back-up denial. That is incorrect. As we discussed above, Bauman permitted an insurer to revoke its acceptance and deny a claim based upon a showing of fraud, misrepresentation or other illegal activity. Because of the apparent misunderstanding of Bauman, Senator Brenneman appeared to believe that amended ORS 656.262(6) was expanding, rather than contracting, an insurer's authority to issue a back-up denial. Accordingly, we are not persuaded by Senator Brenneman's statement that the legislature intended to overrule Bauman in its entirety.

Ross Dwinell, member of the Governor's Workers' Compensation Labor-Management Advisory Committee, also addressed amended ORS 656.262(6):

> "This allows for insurers and self-insured employers to back up and deny a claim that was first denied [sic] in good faith.
>
> "* * * *
>
> "[T]his caps at two years, incidentally, where Bauman was unrestricted as far as fraud is concerned it could go out twenty years. * * * We're saying in that those situations, if the evidence comes about within two years after the claim's been accepted, and we've shifted the burden to the insurer to prove the claim is not compensable, then we're saying those back-up denials will be sustained in those types of circumstances." Minutes, Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side B at 221.

Mr. Dwinell appears to say that amended ORS 656.262(6) would impose, without exception, a two-year "cap" on back-up denials. Upon closer examination, however, we are not persuaded that was his intent. Rather, we are persuaded he was merely distinguishing amended ORS 656.262(6), which allows an insurer to

issue a back-up denial within two years if the claim is found noncompensable, from the Bauman rule, which allows the insurer to issue a back-up denial at any time, but only in cases involving fraud, misrepresentation or other illegal activity. That is, if claim acceptance is induced by fraud, misrepresentation or other illegal activity, an insurer may issue a back-up denial at any time; otherwise, the insurer must issue the denial within two years after acceptance. We do not read Mr. Dwinell's comments to mean that, after two years from the date of acceptance, an insurer is prohibited from issuing a back-up denial based on a showing of fraud, misrepresentation or other illegal activity. Moreover, Mr. Dwinell's testimony regarding ORS 656.268(14) (involving fraudulently-obtained benefits) seems to suggest that, as between that provision and ORS 656.262(6), only ORS 656.268(14) addresses the issue of fraud. Minutes, Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 2, Side B at 180.

Therefore, the legislative history does not establish clear and unambiguous intent to overturn the Bauman rule in its entirety. Given the overriding public policy of preserving the integrity of the worker's compensation system, we are compelled to conclude that the legislature did not intend to prohibit denials of fraudulent claims more than two years after claim acceptance. Accordingly, the insurer's back-up denial in this case is permissible so long as it is supported by a showing of fraud, misrepresentation or other illegal activity.[2]

Merits of Back-up Denial

The insurer bears the burden of proving fraud, misrepresentation or other illegal activity, in order for its back-up denial to be effective. See Bauman v. SAIF, supra. Moreover, "[i]n order to justify a backup denial, a misrepresentation must have been sufficiently material that the insurer's decision [to accept the claim] 'could reasonably have been affected.'" SAIF v. Abbott, 103 Or App 49, 52-53 (1990), (quoting Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987)).

At hearing, the insurer agreed that it bears the initial burden of proof in support of its denial of the accepted aggravation claim. (Tr. 13). When the hearing first convened, the insurer represented that it might be able to produce evidence of fraud, based on claimant's failure to report his January 1986 injury in Washington. (Tr. 7). However, the only evidence which arguably supports the insurer's contention that claimant's failure to report constituted material fraud or misrepresentation are doctors' reports which speculate that the knowledge of an intervening injury might have affected their opinions. (See Exs. 28A & 31).

We assume for the moment that such speculations could be persuasive. Nevertheless, in view of the insurer's awareness that several years had passed since it accepted claimant's aggravation claim and its failure to investigate

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[2] The Court of Appeals recently commented in SAIF v. Abbott, 103 Or App 49, 53 n.1 (1991), that "[t]he so called 'Bauman rule' on retroactive denials was repealed effective July 1, 1990, by Or Laws 1990 (Special Session), ch 2, 15." However, inasmuch as the 1990 amendments did not apply in that case, the court's comment was dicta and therefore not controlling in this case. Furthermore, it is not clear whether the court was addressing Bauman's general prohibition of back-up denials, which we agree was repealed by amended ORS 656.262(6), or the specific exception that permits back-up denials in cases involving fraud, misrepresentation or other illegal activity, which we have concluded was not repealed.

potential intervening causal factors, we are not persuaded that claimant's omissions in reporting were sufficiently material to reasonably affect the insurer's decision to accept the claim. See Abbott, supra at 53. In addition, we note that x-rays of claimant's left wrist, before and after the 1986 incident in Washington, consistently revealed degenerative changes only. (See Exs. 10-1, 13-4, 14-2, 15-1). There is no medical evidence that the 1986 Washington accident caused a trauma to claimant's left wrist. For these reasons, as well as those articulated by the Referee, we conclude that the insurer has not carried its burden of proving fraud, misrepresentation or other illegal activity in support of its denial. Therefore, the Referee properly set aside the denial, and the insurer is barred from denying the compensability of claimant's left wrist condition. See David K. Boyer, 43 Van Natta 561, 563 (1991).

Motion to dismiss or continue

The Referee decided that claimant's absence from the hearing and unavailability for cross-examination did not justify dismissal or a second postponement. We agree. In this regard, we are unpersuaded by the insurer's argument that it was deprived of a fair hearing due to claimant's unavailability.

The insurer contends that claimant's truthful testimony would have established fraud or misrepresentation, or, alternatively, that his untruthful testimony would have been impeached. However, in view of our conclusion that claimant's apparent failure to report his Washington injury does not constitute material misrepresentation or fraud, the insurer's contentions are speculative and therefore unpersuasive. We conclude that the insurer was not deprived of a fair hearing.

Because the insurer initiated the request for review and we have not disallowed or reduced claimant's compensation, claimant's counsel is entitled to an assessed fee under 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 is $800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value to claimant of the interest involved.

ORDER

The Referee's order dated January 3, 1991 is affirmed. For his services on review, claimant's attorney is awarded a reasonable assessed fee of $800, to be paid by the insurer.

February 12, 1992 Cite as 44 Van Natta 244 (1992)

In the Matter of the Compensation of
NATALIA GARIBIAN, Claimant
WCB Case No. 90-02608
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Emerson's order that: (1) held that res judicata barred her temporomandibular joint dysfunction (TMJ) claim; and (2) dismissed her request for hearing challenging the SAIF Corporation's "de facto" denial of that condition. In her brief, claimant asserts that, if her TMJ claim

is not precluded by res judicata, this matter should be remanded to the Referee for a decision on the merits. On review, the issues are res judicata, remand, compensability, medical services, and penalties and attorney fees. We modify the Referee's order, deny the remand request, and address the merits of claimant's TMJ claim.

FINDINGS OF FACT

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

SAIF's December 2, 1988 denial was solely of claimant's chronic vestibular disorder, diagnosed as bilateral perilymph fistulas.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee found that the parties had entered into an April 25, 1989 stipulation that purported to settle "all issues raised or raisable" at that time, and claimant's TMJ condition arose out of the same set of operative facts as her vestibular disorder which was settled by the stipulation. The Referee concluded that claimant could have raised the issue of compensability of her TMJ condition at the time of the stipulation, and because she failed to do so, her TMJ claim was barred.

The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 38, 50, modified 305 Or 468 (1988). Both issue and claim preclusion apply to worker's compensation proceedings. Drews v. EBI Companies, 310 Or 134 (1990). Under the rule of claim preclusion, if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same cause of action or any part thereof. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); see also Restatement (Second) of Judgments, 17-19, 24 (1982). A Referee's order approving a disputed claim settlement is a final "judgment" within the meaning of this rule. See Patricia S. Thompson, 42 Van Natta 648 (1990), citing Proctor v. SAIF, 68 Or App 333 (1984).

Here, claimant had been diagnosed with bilateral perilymph fistulas (bilateral vestibular disorder) and bilateral TMJ dysfunction following a non-work related auto accident in 1987. The conditions were treated conservatively.

On October 10, 1988, claimant filed a claim for injury to the left and right ears. SAIF denied the request on December 2, 1988. SAIF's denial letter expressly denied an "exacerbation of chronic vestibular disorder." Claimant requested a hearing to contest the denial. On April 25, 1989, a referee approved a stipulation that provided that SAIF rescinded its denial and agreed to accept claimant's claim for a worsening of her preexisting bilateral vestibular disorder, arising from the October 3, 1988 incident.

We find no language in the settlement agreement that expressly settles the issue of compensability of claimant's TMJ condition. Moreover, there is no evidence that claimant had submitted bills for her TMJ condition to SAIF, nor that the TMJ condition had been denied by SAIF prior to the stipulation. Rather, claimant had received treatment for her vestibular disorder and SAIF had expressly denied that condition. It was not until after the stipulation had been entered into that Dr. Potter saw claimant for consultation on June 7, 1989, and it was at that time that Dr. Potter confirmed the diagnosis of TMJ dysfunction. On November 22, 1989, Dr. Potter requested authorization for surgery to correct the TMJ condition.

Accordingly, we conclude that the April 25, 1989 settlement did not litigate to final judgment the issue of compensability of claimant's TMJ condition. See, e.g., Dave E. Herman, 42 Van Natta 2104 (1990)(status of the controversy going into a DCS involved a venous insufficiency condition and did not expressly "bargain away" the right to medical services for the claimant's accepted low back condition. Furthermore, nothing in the settlement indicated that claimant either specifically requested or the employer expressly denied medical services for the low back condition, therefore, the DCS did not litigate the issue to final judgment). Under the circumstances, we conclude that the settlement agreement is not res judicata as to claimant's claim for her TMJ condition.

Remand

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Although claimant has requested remand for a further hearing on the merits of claimant's TMJ claim, we do not find that the record has been improperly or incompletely developed. Accordingly, we deny claimant's motion for remand, and we address the merits on review.

Compensability of TMJ condition

Dr. Conrad, internist, reported that, on October 3, 1988, claimant had a "marked worsening of her (perilymph fistulas) condition related to a firecracker that was set off in her classroom. This did exacerbate her inner ear dysfunction and with increased muscular tension her temporomandibular joint (jaw joint) pain." On March 8, 1990, Dr. Conrad reported that claimant continued to suffer from the TMJ and vestibular dysfunction conditions, "both brought about or exacerbated by the injury of October 3, 1988."

On March 16, 1990, claimant was examined by the Objective Medical Assessments Corporation. The physicians reported that claimant had moderate TMJ syndrome, possibly caused or aggravated by the auto accident of July 1987, but "unlikely to be aggravated by the firecracker incident." The OMAC physicians concluded that the TMJ problem, "also may have preexisted, at least in some degree."

As a result of the April 25, 1989 stipulation, SAIF has accepted compensability of the October 3, 1988 work incident. Claimant now seeks benefits related to her TMJ dysfunction. Claimant suffered from TMJ dysfunction prior to the compensable injury. Claimant's medical evidence states that her compensable injury has combined with her preexisting TMJ dysfunction to cause a need for treatment. Accepting that evidence, claimant's resulting TMJ condition is compensable only if the compensable injury is the major cause of her need for treatment. ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991).

Dr. Conrad's opinion does not persuade us that the October 3, 1988 firecracker incident is the major cause of claimant's current need for TMJ treatment. Dr. Conrad's opinions are conclusory and, therefore, we give them little weight. See Somers v. SAIF, 77 Or App 259 (1986). In addition, Dr. Conrad suggests that the October 3, 1988 injury may have "brought about" the TMJ condition. This is clearly contrary to the other evidence in the record. Moreover, Dr. Conrad offers no opinion as to the relative contribution to claimant's current need for treatment as between the preexisting TMJ dysfunction and the compensable injury. By contrast, the OMAC physicians have opined that it was unlikely that claimant's TMJ condition was aggravated by the firecracker incident.

We conclude that claimant has failed to establish that the October 1988 incident is the major cause of her disability or need for treatment. Under the circumstances, we conclude that claimant has failed to establish compensability of her TMJ condition.

Authorization for surgery

Because we have concluded that claimant has failed to prove compensability of her TMJ condition, we do not address the surgery authorization issue.

Penalties and attorney fees/unreasonable denial

As we have found that claimant's TMJ claim is not compensable, there can be no unreasonable resistance to the payment of compensation. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). Therefore, claimant is not entitled to a penalty and related attorney fee.

ORDER

The Referee's order dated May 16, 1991 is modified. Claimant's request for hearing is reinstated. The SAIF Corporation's "de facto" denial of claimant's TMJ condition is upheld.

February 12, 1992 Cite as 44 Van Natta 247 (1992)

In the Matter of the Compensation of
PEDRO MENDOZA, Claimant
WCB Case Nos. 90-12948 & 90-12949
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David Fowler (Saif), Defense Attorney
David Horne, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Wausau Insurance Company requests review of those portions of Referee Spangler's order that: (1) found that claimant had established "good cause" for his untimely hearing request from Wausau's denial of his "new injury" claim for a low back condition; and (2) set aside Wausau's denial. On review, Wausau contends that claimant has not established good cause for his untimely hearing request. We agree and reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

We do not adopt the Referee's "Ultimate Findings of Fact." We add the following finding of fact.

Claimant's hearing request was not filed within 60 days of claimant's notice of Wausau's June 25, 1990 denial and claimant did not have good cause for the late request.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's untimely hearing request was due to the negligence of his attorney's legal assistant, the Referee concluded that claimant had established good cause to excuse his failure to request a hearing within 60

days. While we agree that the untimely request was caused by the negligence of the legal assistant, we do not agree that this constitutes good cause.

A request for a hearing must be filed not later than the 60th day after claimant is notified of a denial of a claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b).

Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). While the neglect of an attorney's employee who is not responsible for handling hearing requests may be excusable neglect, see Brown, supra at 460, neglect by an attorney or by an attorney's employee who is responsible for filing hearing requests is not excusable and does not constitute good cause for untimely filing. See Sekermestrovich v. SAIF, 280 Or 723, 727 (1977); EBI Companies v. Lorence, 72 Or App 75, 78 (1985).

Here, claimant did not request a hearing on the June 25, 1990 denial until just before the November 6, 1990 hearing, (on issues not relevant here), more than 60 days, but less than 180 days after Wausau's denial. At hearing, Ms. Jordan, claimant's attorney's legal assistant, testified that her workers' compensation case responsibilities included filing requests for hearings. (Tr. 25). She said that the law office used red cards to track deadlines for denials through a diary system and that the cards were normally kept separate from the claimant's files, unless the attorney indicated the denial would not be appealed. (Tr. 26 and 37). While Jordan did not know for sure when the law office had received notice of Wausau's denial, she speculated that claimant may have called when he got the denial or the denial may have come into the office by mail and that it probably was received sometime between the date of the denial, June 25, 1990, and July 25, 1990, the date recorded on the red diary card. (Tr. 31-32).

Jordan further testified that on October 18, 1990 when she received Wausau's exhibit list, she reviewed claimant's file, found the denial and a misfiled red diary card, and realized that she had failed to file a request for a hearing. (Tr. 31-32). She also found a note regarding a claims processing issue and recalled that, "at one point," she had been instructed by claimant's attorney to file a request for a hearing. (Tr. 34). Jordan admitted, however, that due to various personal reasons, she failed to file claimant's request for a hearing before the 60-day deadline. (See Tr. 36 and 38).

Relying on our decision in Ronald L. Schilling, 42 Van Natta 2566 (1990), aff'd mem Schilling v. Brothers Landscaping et al, 109 Or App 494 (1991), Wausau argues that claimant failed to show good cause because the untimely request was caused by either the inexplicable misfiling of the red diary card in claimant's file or by Ms. Jordan's neglect, which was inexcusable since she was the person responsible for filing claimant's request for a hearing.

In Schilling, a denial was received in claimant's counsel's office and was misfiled in another claimant's file. At hearing, the claimant's counsel at first indicated his legal assistant had asked his secretary to request a hearing, but later said that he was not sure who had caused the untimely request. Id. at 2567. We concluded that the claimant had failed to establish good cause because, based on those facts, we could not determine whether the untimely request was caused by the excusable neglect of the secretary, who was not

responsible for handling requests, or by the inexcusable neglect of the legal assistant, who was responsible for such matters. Id.

In contrast, in this case we can and do find that the untimely request was caused by the legal assistant, who was responsible for requesting claimant's hearing and admittedly forgot to make that request due to personal reasons even after claimant's attorney reminded her. We do not find the fact that the red diary card had been misfiled significant since we conclude that, even after the misfiling, the legal assistant was reminded to request a hearing and forgot to do so. Accordingly, because failure to request a hearing by someone charged with that responsibility is not excusable neglect, we hold that claimant has failed to establish good cause for his untimely request and his request for a hearing as to Wausau's denial should have been dismissed for want of jurisdiction. See Sekermestrovich v. SAIF, supra; EBI Companies v. Lorence, supra.

ORDER

The Referee's order dated April 26, 1991 is reversed in part and affirmed in part. Claimant's request for hearing as to the Wausau Insurance Company's June 25, 1990 denial of his "new injury" claim is dismissed. Wausau's denial is reinstated. The Referee's award of an assessed attorney of $2,000 is reversed. The remainder of the Referee's order is affirmed.

February 12, 1992 Cite as 44 Van Natta 249 (1992)

In the Matter of the Compensation of
LINDA D. THOMAS, Claimant
WCB Case No. 90-14356
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Livesley's order that upheld the self-insured employer's denial of her aggravation claim for a left shoulder condition. On review, the issue is aggravation.

We affirm and adopt the Referee's order, except for his finding of fact that claimant's last award or arrangement of compensation was a Determination Order dated June 26, 1990. Instead, we find that claimant must prove a worsening since the date of the final opportunity to present evidence, which was May 31, 1990. Joseph Klinsky, 35 Van Natta 332, aff'd mem., 66 Or App 193 (1983).

ORDER

The Referee's order dated April 8, 1991, is affirmed.

In the Matter of the Compensation of
ARNOLD L. RODACKER, Claimant
WCB Case No. 90-12618
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Galton's order which increased claimant's unscheduled permanent disability award for a right shoulder condition from 24 percent (76.8 degrees), as awarded by a Determination Order, to 30 percent (96 degrees) and awarded no scheduled permanent disability. On review, the issues are the extent of scheduled and unscheduled permanent disability.

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

Claimant first contends that he is entitled to scheduled permanent partial disability based on loss of use of his right arm. Specifically, claimant asserts that he proved that he has decreased grip strength, entitling him to a 30 percent award, and chronic pain and discomfort, entitling him to a 5 percent award.

In regard to decreased grip strength, claimant relies on former OAR 436-35-110(3)(d), which provides impairment values for "decreased grip strength due to atrophy or other anatomical changes (except amputations and nerve damage)[.]" There is evidence that, upon testing by Dr. Nathan, M.D., a hand specialist, the grip strength of the right hand was found to be significantly less than that of the left hand. (Ex. 5A-3). However, the testing occurred on May 8, 1989, some time before claimant's medically stationary date of March 29, 1990. Later testing on March 6, 1990 by the Western Medical Consultants also revealed "giveaway of all muscle testing on the right" but it was noted that claimant exhibited "obvious lack of effort with grip testing on the right to both manual and instrument testing by this examiner." (Ex. 10-4). Moreover, Dr. Sirounian, orthopedic surgeon, who saw claimant on referral from his treating physician, noted "no loss of hand grasp strength" and "no evidence of any intrinsic muscle weakness." (Ex. 14-2). Finally, a return to work recommendation performed on April 20, 1990 by claimant's treating physician, Dr. Harris, D.C., stated that claimant could perform repetitive fine manipulation and simple grasping with his hands. (Ex. 18A).

Former OAR 436-35-010(7) allows for a 5 percent rating for "chronic conditions limiting repetitive use of a scheduled body part[.]" If such chronic condition is pain, however, it is considered in rating scheduled permanent disability "to the extent it results in measurable impairment." Former OAR 436-35-010(2)(b); Susan L. Ferguson, 42 Van Natta 2382 (1990). Here, the record is bare of any evidence that pain has resulted in measurable impairment.

Based upon the evidence noted above, we conclude that there was no evidence of decreased grip strength in claimant's right arm or that pain resulted in measurable impairment. The Referee correctly found claimant is not entitled to scheduled permanent partial disability benefits.

Claimant next argues that, in computing his unscheduled permanent partial disability benefits, he is entitled to an additional 5 percent award under former OAR 436-35-320(4) because he suffers from "chronic shoulder pain and inflammation," limiting repetitive use of his right shoulder.

As in computing scheduled permanent disability, pain is considered in rating impairment in the unscheduled permanent disability context "to the extent that it results in measurable impairment." Former OAR 436-35-320(1); William K. Nesvold, 43 Van Natta 2767 (1991). Again, there is no evidence that pain resulted in measurable impairment. Claimant is not entitled to an additional 5 percent award under former OAR 436-35-320(4).

ORDER

The Referee's order dated April 16, 1991 is affirmed.

In the Matter of the Compensation of
ANTHONY M. SABBATO, Claimant
WCB Case No. 90-09151
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Harri's order that: (1) set aside its denial of claimant's injury claim for his lung condition; and (2) assessed penalties and a penalty-related attorney fee for unreasonable delay in claims processing. On review, the issues are compensability, penalties and attorney fee. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as our own, and supplement with the following findings.

Claimant's asthma has been exacerbated by smoking one to one-and-one-half packs of cigarettes a day since age 16. Dr. Kintz, claimant's treating pulmonologist, has advised claimant to cease smoking.

Dr. Bardana, independent allergy and immunology specialist, examined claimant on April 4, 1990. Pulmonary function studies performed as a part of that examination reveal that claimant has bronchial asthma with moderately severe obstructive airway disease consistent with protracted cigarette usage.

Claimant filed a request for hearing on April 27, 1990; the hearing was convened on July 16, 1990.

FINDINGS OF ULTIMATE FACT

Claimant's injury (allergic reaction to paint thinner fumes) on December 6, 1989 arose out of and in the course of employment and was a material contributing cause of his disability and need for medical treatment. The December 6, 1989 compensable injury is not the major contributing cause of claimant's resulting lung condition or need for medical treatment.

Applicable Law

On review, claimant contends that the 1990 amendments to the Oregon Workers' Compensation Law do not apply to this case because the hearing "should have been" convened before July 1, 1990. We disagree.

Oregon Laws 1990 (Special Session), chapter 2, 54(2) provides for application of the pre-amendment laws where a request for hearing was filed before May 1, 1990 and a hearing was convened before July 1, 1990. The statute refers to when the hearing was held, rather than when a party expected the hearing to be held. Id. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Compensability

Turning to the merits of the claim, the Referee found that claimant's exposure to fumes at work was a material cause of his worsened preexisting condition and need for medical treatment. Accordingly, he set aside the insurer's denial. We modify.

In cases involving preexisting conditions, we have held that whether a claim is compensable is a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that he suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of his disability or need for medical treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Claimant's disability or need for medical treatment must be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). Then, if it is determined that there is a preexisting condition and that the condition combined with the injury to cause or prolong disability or need for treatment, claimant is entitled to disability compensation and treatment if the injury was the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B).

On this record, we first conclude that claimant has established the compensability of his December 6, 1989 injury. The insurer concedes that "[claimant's] exposure to the solvent [at work] . . . provoke[d] a single episode of breathing difficulty." There is no dispute that, while in the course and scope of his employment, claimant was exposed to paint thinner fumes containing the chemical xylene, causing an allergic reaction that triggered an asthmatic attack. Claimant immediately reported this incident to the insured, and left work for the remainder of his shift. Moreover, the next day he sought emergency room medical treatment. An exacerbation of asthma was diagnosed. The medical evidence establishes that the December 6, 1989 injury was a material contributing cause of claimant's disability on December 6, 1989 and need for medical services on December 7, 1989. Accordingly, we conclude that claimant has established a compensable injury.

We next consider whether claimant's compensable injury has combined with his preexisting asthma condition to cause or prolong his disability or need for treatment, and whether the injury is the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B). We find that the causation of claimant's resulting lung condition presents a complex medical question, the resolution of which depends 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). We find Dr. Bardana's opinion on the issue of claimant's resultant disability and need for treatment to be more persuasive than that of Dr. Kintz.

Claimant has treated with Dr. Kintz since 1982. During that time, Dr. Kintz has hospitalized claimant for noncompliance with his medication regimen and asthmatic attacks triggered by viral infections. His chart notes reveal ongoing concern for claimant's poor treatment compliance and continued heavy smoking, despite being counseled as to its detriments. Dr. Kintz expressed no opinion as to the cause of claimant's worsened asthmatic condition until after Dr. Bardana submitted his extensive report attributing claimant's worsened condition to tobacco abuse. Then, in a brief note, Dr. Kintz opined that it is "likely that the worsening of [claimant]'s asthma has been related to paint fumes."

We find Dr. Kintz's report to be conclusory, without explanation or analysis. Therefore, we give his opinion little weight. Moreover, it does not address the major contributing cause standard that claimant must prove in order to establish the compensability of his resultant condition. Finally, although Dr. Kintz is aware of other exposures and potential causes for claimant's current lung condition, he does not indicate whether he considered the effects of below-therapuetic doses of medication or continued smoking as potentially contributory factors to claimant's condition.

Dr. Bardana, on the other hand, explains in detail the contributing factors to claimant's condition and further explains why the work exposure was not contributory to claimant's symptoms or condition after claimant's initial reaction. The doctor based his conclusion on a review of all of claimant's prior medical records, an interview with claimant, claimant's history as a smoker, his familial predisposition to asthma, a complete physical examination, special breathing testing, and a review of the medical literature concerning the effects of smoking on asthmatics. Dr. Bardana then explained in a comprehensive report that the primary external factor adversely affecting claimant's lung disease is his abuse of tobacco. We find Dr. Bardana's well-reasoned opinion to be persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

We find that claimant has failed to establish that his workplace exposure to paint thinner, in comparison with his tobacco use and noncompliance with medications, is the major contributing cause of his worsened asthma condition and subsequent disability and need for medical treatment. Accordingly, although claimant has established the occurrence of a compensable injury on December 6, 1989, his resulting condition is not compensable. Therefore, pursuant to ORS 656.005(7)(a)(B), the insurer's denial is upheld to the extent that it denied compensation for claimant's current disability or need for treatment.

Penalties and Attorney Fee

We agree with the Referee that the insurer's conduct was unreasonable. Consequently, we affirm that portion of the Referee's order which assessed a 10 percent penalty based on the compensation unpaid at the time of the insurer's untimely denial.

However, we reverse that portion of the Referee's order which awarded a separate $200 insurer-paid attorney fee. Subsequent to the Referee's order we held that, when the factual basis for the assessment of a penalty under ORS 656.262(10) is identical to the factual basis for an attorney fee under ORS 656.382(1), claimant is not entitled to a separate fee under ORS 656.382(1) but rather claimant's attorney shall receive one-half of the penalty under ORS 656.262(10) "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991). Thus, in accordance with ORS 656.262(10), we modify the Referee's order to provide that one-half of the penalty assessment is paid to claimant's attorney in lieu of an attorney fee.

Finally, because we have upheld the insurer's denial insofar as it denied the compensability of claimant's resultant condition and need for medical services, we modify the assessed fee awarded by the Referee at hearing. In lieu of the Referee's award of an $1,800 assessed fee for setting aside Liberty's denial, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by Liberty. In reaching this determination, we have considered the factors set forth in OAR 438-15-010(4).

The insurer requested review. We have found that claimant's claim should be partially disallowed. Nevertheless, claimant's attorney is entitled to a reasonable assessed fee for his services on review concerning the initial compensability issue. 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 is $400, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue as represented by claimant's brief, the complexity of the issue, and the value of the interest involved.

Inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the Referee's attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated August 14, 1990 is affirmed in part, modified in part, and reversed in part. The insurer's April 24, 1990 denial is reinstated and upheld to the extent that it denies responsibility for any treatment and/or disability concerning claimant's current resulting lung condition. That portion of the insurer's denial which denied that claimant sustained a compensable injury on December 6, 1989 is set aside and the claim is remanded to the insurer for processing in accordance with law. In lieu of the Referee's award of an $1,800 assessed fee for setting aside the insurer's denial, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer. The Referee's $200 insurer-paid attorney fee for an untimely denial is reversed. The Referee's award of a 10 percent penalty based on the unpaid compensation due at the time of the insurer's denial shall be paid by the insurer in equal proportions to claimant and his attorney.

In the Matter of the Compensation of
GERALD D. SPENCER, Claimant
Own Motion No. 66-0226M
OWN MOTION ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our January 14, 1992 Own Motion Order in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our January 14, 1992 Own Motion Order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WCB Case No. 90-10882
STEVEN V. BISCHOF, Claimant
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Hoguet's order that ordered it to pay claimant temporary disability benefits from March 16, 1990 through September 10, 1990. On review, the employer argues that the Hearings Division did not have jurisdiction over the issue of whether claimant's claim was disabling or nondisabling. Claimant cross-requests review of that portion of the Referee's order which declined to award an assessed fee for prevailing on a denied claim. The issues on review are jurisdiction, temporary disability, and attorney fees. We vacate the Referee's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law in effect before the 1990 amendments. See Oregon Laws 1990 (Special Session), SB 1197. We apply the law in effect after the amendments for the following reasons.

Claimant requested a hearing after May 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Jurisdiction

The Referee accepted as adequate the Department of Insurance and Finance's (DIF) response to claimant's request to have his claim reclassified from nondisabling to disabling. The employer contends that DIF's response does not meet the requirements of ORS 656.268(9) and (11). Therefore, the employer argues, claimant has failed to exhaust the required administrative remedy prior to requesting a hearing. Claimant argues that he exhausted his administrative remedy by requesting DIF to reclassify his claim. We find that we lack jurisdiction because DIF has not yet issued a Determination Order pursuant to ORS 656.268(11).

Section 48 provides, in pertinent part:

> "(1) If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the director for determination pursuant to ORS 656.268.
>
> " * * * *

"(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

" * * * *

"(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon . . . ."

On March 2, 1990, claimant's treating physician released him from work for two weeks due to the injury. (Exs. 4-2, 16). When the employer received this release, it should have reported to DIF that claimant alleged that the nondisabling claim had become disabling. The record is clear that the employer had notice of this claim by March 30, 1990, well within one year of claimant's February 2, 1990 date of injury. The employer did not report the claim to DIF; instead, it issued a denial denying that the claim was disabling. (Ex. 22). The employer also submitted a 1502 form dated March 20, 1990 to DIF. This 1502 form described the status of the claim as a "denied, disabling, original injury." (Ex. 23).

Claimant then requested that DIF reclassify the claim. On April 30, 1990, in response to this request, DIF sent a letter to claimant's attorney which stated:

"In response to your letter dated March 29, 1990 please be advised that this claim has alredy [sic] been classified as disabling per the 1502 form dated March 20, 1990. (copy enclosed).

"Your request for reclassification from non-disabling to disabling has been resolved and therefore we have no action to take at this time." (Ex. 25).

ORS 656.268(11) provides:

"Upon receipt of a request made pursuant to ORS 656.262 of this section or section 48 of this 1990 Act, the Department of Insurance and Finance shall determine whether the claim is disabling or nondisabling. A copy of such determination shall be mailed to all interested parties in accordance with this section."

We find that DIF's April 30, 1990 letter does not constitute a determination of "whether the claim is disabling or nondisabling" pursuant to ORS 656.268(11). This letter did not address the merits of the reclassification request. Instead, it stated that the claim was already classified as disabling based on an erroneous assumption that the employer had accepted the claim as disabling. Furthermore, the letter was not mailed to all interested parties.

Because the Evaluation Section has not yet issued a determination pursuant to ORS 656.268(11), we conclude that we lack jurisdiction to address whether the accepted nondisabling injury has, in fact, become disabling. See Christine A. Degrauw, 44 Van Natta 91 (1992). Upon issuance of that determination, any interested party may then vest jurisdiction with the Hearings Division by requesting a hearing on that order pursuant to ORS 656.268(9).

ORDER

The Referee's order dated April 3, 1991 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction. The Referee's attorney fee award is vacated.

In the Matter of the Compensation of
DENNIS C. BUSH, Claimant
WCB Case No. 90-19369
ORDER OF ABATEMENT
Schouboe & Furniss, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of our January 28, 1992 Order on Review.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn. Claimant is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN E. JONES, Claimant
WCB Case Nos. 89-11250 & 89-08974
ORDER ON REMAND
Hollis Ransom, Claimant Attorney
Yturri, et al., Defense Attorneys
Employers Defense Counsel, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Cameron Logging v. Jones, 109 Or App 391 (1991). The court has reversed our prior order which affirmed and adopted a Referee's order finding Liberty Northwest (Cameron Logging), rather than Liberty Northwest (Dougherty Logging), responsible for claimant's current back condition. The court was unable to determine whether we had properly applied the burden of proof to Dougherty Logging, the last employer with an accepted claim. In addition, the court could not determine whether we had found that claimant suffered a "new injury" while working for Cameron Logging (even in the absence of a specific injurious incident) or merely an aggravation of his prior injury with Dougherty Logging. Consequently, the court remanded for reconsideration of these matters.

After conducting our reconsideration, we affirm and adopt the order of the Referee with the following modification and supplementation.

The last employer with an accepted claim relating to a specific body part bears the burden of proving that a new injury at the subsequent employment independently contributed to a worsening of the claimant's underlying condition. Stevens Equipment Co. v. American Fabricators, 106 Or App 354, rev den 311 Or 482 (1991).

Here, Dougherty Logging, as the employer who had accepted claimant's 1986 back injury claim, was the last employer with an accepted claim for claimant's back. As such, Dougherty Logging has the burden of proving that claimant suffered a new injury to his back while working for Cameron Logging.

Responsibility for claimant's back condition can shift to Cameron Logging provided that Dougherty Logging proves that claimant's subsequent employment with Cameron Logging independently contributed, even slightly, to a worsening of claimant's underlying back condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

The absence of a specific injurious incident is not determinative as to whether claimant had suffered a new injury while working for Cameron Logging. Hensel Phelps Construction v. Mirich, supra, at page 293.

After completing our review of the lay and medical evidence, we are persuaded that claimant's subsequent employment with Cameron Logging between June 1987 and August 1988 independently contributed to a worsening of claimant's underlying back condition. In reaching this conclusion, we rely on the opinion of Dr. Whalen, claimant's treating chiropractor. Whalen concluded that claimant's condition had worsened as a result of "multiple injuries that have occurred over the years through multiple jobs requiring heavy lifting, hard manual labor." (Ex. 40).

Inasmuch as claimant's most recent employment was with Cameron Logging and since his duties included heavy lifting and manual labor, we interpret Dr. Whalen's opinion as a determination that claimant's employment with Cameron Logging independently contributed to a worsening of claimant's back condition. Because we have found that claimant's subsequent employment with Cameron Logging independently contributed to a worsening of claimant's underlying back condition, responsibility for claimant's back condition shifts from Dougherty Logging to Cameron Logging.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 9, 1990 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELVIN L. MARTIN, Claimant
WCB Case No. 90-20361
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Nancy C. Marque (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Kinsley's order which: (1) found that the Hearings Division had jurisdiction over the issue of medical services; (2) found that the proposed medical treatment was reasonable and necessary; and (3) awarded an assessed attorney fee with respect to the "de facto" denial of medical services. On review, the issues are jurisdiction, medical services and attorney fees. We vacate the Referee's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the ultimate findings of fact.

ULTIMATE FINDINGS OF FACT

The Hearings Division of the Workers' Compensation Board did not have jurisdiction to hear this matter regarding authorization for proposed medical treatment.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May

1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

On October 22, 1990, SAIF referred the matter of the proposed surgical procedure to the Director of the Department of Insurance and Finance for review pursuant to ORS 656.327 and OAR 436-10-046. On November 1, 1990, before the Director could issue a decision on the matter, claimant requested a hearing pursuant to ORS 656.319, challenging SAIF's "de facto" denial of his requested surgery. The Referee: (1) found that the Director did not have exclusive jurisdiction of this medical services issue because it related to a future procedure rather than current, ongoing treatment; (2) found that the spinal cord stimulation surgery was reasonable and necessary; (3) set aside SAIF's "de facto" denial of medical services; and (4) assessed attorney fees for prevailing against the denial.

We find that the Referee lacked jurisdiction over the issue of SAIF's denial. Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Here, SAIF contends that the proposed trial surgical implantation of a dorsal column stimulator is excessive, inappropriate and ineffectual. Furthermore, SAIF argues that the procedure is experimental and thereby violates OAR 436-10-045(1). Original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See Stanley Meyers, supra. Furthermore, we have recently held that disputes regarding proposed medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992).

Inasmuch as the "de facto" denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate the Referee's order and dismiss claimant's hearing request. We also vacate the Referee's attorney fee award. See Stanley Meyers, supra; Kevin S. Keller, supra.

ORDER

The Referee's order dated April 30, 1991 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction. The Referee's attorney fee award is vacated.

In the Matter of the Compensation of
CHERIE L. MORAN, Claimant
WCB Case No. 90-16097
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of those portions of Referee Brown's order that: (1) found that claimant had established good cause for an untimely filing of a hearing request; and (2) set aside its denial of claimant's claim for bilateral tarsal tunnel syndrome. On review, the issues are timeliness of the hearing request and compensability. We affirm.

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

The employer's denial of claimant's bilateral foot condition was mailed on April 20, 1990. Claimant received the denial on May 26, 1990. She filed her request for hearing on August 8, 1990.

Claimant discussed the denial of her claim with an administrative assistant with her employer, who told her to get an attorney. Claimant had difficulty obtaining an attorney because many of them had conflicts due to claimant's work as an undercover narcotics officer.

On June 5, 1990, the employer's claims administrator sent claimant a copy of a Form 1503 for an unrelated cervical claim. Claimant believed, but was not sure, that the copy of the Form 1503, which indicted an accepted claim, was an acceptance of her foot condition.

On July 17, 1990, a Determination Order concerning the cervical claim was mailed to claimant.

Sometime during the week of July 15 through 19, 1990, claimant again consulted the administrative assistant with her employer, showed her one of the "pink" forms she had received from the claims administrator, and asked whether her claim had now been accepted. The assistant called the claims administrator to inquire, but the workers' compensation claims manager was on vacation. The assistant was referred to another claims manager. She said to the manager that claimant had a form which indicated that the claim had been accepted and she wanted to know what the "acceptance" means. (Tr. 62). The manager responded and the assistant told claimant that since the claim was accepted, claimant could assume that her bill would be paid. (Tr. 61-63, 71).

CONCLUSIONS OF LAW AND OPINION

Timely Request for Hearing

We adopt the Referee's "Opinion" with regard to this issue. See Thomas E. Edison, 44 Van Natta 211 (1992); Alice M. Derrick, 42 Van Natta 2743 (1990); Cary O. Miller, 42 Van Natta 618 (1990).

Compensability

We adopt the Referee's "Opinion" with regard to this issue.

Attorney Fee/Board 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 is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated February 19, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,000, payable by the self-insured employer.

February 14, 1992 Cite as 44 Van Natta 261 (1992)

In the Matter of the Compensation of
RAYMOND THORNSBERRY, Claimant
Own Motion No. 66-0298M
OWN MOTION ORDER OF ABATEMENT
Roll, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant request reconsideration of our January 15, 1992 Own Motion Order in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within ten days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

February 14, 1992 Cite as 44 Van Natta 261 (1992)

In the Matter of the Compensation of
SHARON J. TRUE, Claimant
WCB Case No. 90-16260
ORDER ON REVIEW (REMANDING)
Darrell E. Bewley, Claimant Attorney
Dennis S. Martin (Saif), Defense Attorney

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Quillinan's order which: (1) held that SAIF was precluded from issuing a "back-up" denial of claimant's hepatitis claim; and (2) set aside SAIF's denial. On review, the issue is the propriety of SAIF's "back-up" denial. We reverse and remand.

PRELIMINARY MATTER

Claimant moves to strike SAIF's brief, contending that SAIF is attempting to "collaterally attack" a previous order that was issued in a separate hearing. We disagree with claimant's characterization of SAIF's appellate brief. We interpret SAIF's arguments as limited to the order issued by the Referee in this proceeding and not as a "collateral attack" on another order. Consequently, the motion to strike is denied.

FINDINGS OF FACT

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

On May 8, 1989, claimant filed a claim for a hepatitis condition. SAIF denied the claim on June 30, 1989. Thereafter, claimant requested a hearing concerning the denial.

On November 17, 1989, SAIF received a November 13, 1989 letter from Dr. Rowher, claimant's treating physician. Rowher considered claimant's work place to have been the source with the highest probability of contact for claimant's hepatitis.

On December 8, 1989, one day before hearing, SAIF rescinded its denial. SAIF formally accepted the claim on the day of hearing, December 9, 1989.

On April 18, 1991, SAIF issued a "back-up" denial. SAIF contended that it had obtained evidence that claimant was not exposed to hepatitis during her employment with SAIF's insured.

CONCLUSIONS OF LAW AND OPINION

In this case, SAIF originally denied the claim, concluding that it was not compensable. A hearing was scheduled to litigate the issue of compensability. On the day of the December 9, 1989 hearing, however, SAIF admitted that the claim was compensable and accepted it.

On April 17, 1991, Referee Baker, who presided over the hearing, issued an interim order stating that "[a]t the hearing claimant sought to present evidence on the merits of compensability of the claim. The referee denied that, concluding that SAIF's admission of compensability was a complete substitution for evidence proving compensability." On April 18, 1991, less than two years after its acceptance of the claim, SAIF issued a "back-up" denial, again disputing compensability.

Referee Baker issued a final order on May 20, 1991, incorporating the terms of the interim order. The May 20, 1991 order also stated that the "only issue remaining following hearing in this matter was claimant's entitlement to an assessed attorney fee when the insurer admitted compensability."

The parties proceeded to hearing on SAIF's "back-up" denial. At the hearing, the parties agreed that they were not prepared to proceed to the merits of the denied claim, but rather would address the procedural validity of the denial. Following the submission of the parties' legal arguments, Referee Quillinan set aside the "back-up" denial based on her conclusion that such an action was precluded by res judicata. The Referee based that conclusion on her findings that the parties had an opportunity to litigate the issue of compensability, a final judgment issued ordering the claim to be compensable, and the parties were identical in this and the previous hearing.

Res judicata is comprised of two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Claim preclusion, on the other hand, does not require actual litigation of an issue or that the determination of the issue be essential to the final decision reached. Rather, a claim is barred if it is based on the same factual

transaction that was at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). Moreover, there must be a prior opportunity to litigate the claim, whether or not used, and there must be a final judgment. Id.

Here, there was no "actual litigation" of the compensability issue. Referee Baker's interim order specifically stated that the Referee refused to allow claimant to introduce evidence concerning compensability. We, therefore, conclude that issue preclusion is not applicable to this case.

We turn to a consideration of claim preclusion. Although compensability was not litigated at the prior hearing, application of claim preclusion does not require actual litigation. Rather, claim preclusion will apply where the "opportunity to litigate" is available. The opportunity to litigate compensability was clearly available to SAIF at the time of the December 8, 1989 hearing. Compensability was not litigated due to SAIF's decision not to avail itself of that opportunity but instead to rescind its denial and accept the claim. Moreover, the parties proceeded to hearing on the attorney fee issue, the resolution of which depended upon compensability of the claim. Accordingly, we conclude that the hearing necessarily related to the same set of operative facts as involved in the compensability question. Carr v. Allied Plating Co., 81 Or App 306, 310 (1986) (the operative facts that should be viewed as included within a single cause of action must be determined pragmatically, on the basis primarily of practical trial convenience considerations).

However, SAIF asserts that, pursuant to amended ORS 656.262(6), it had an unconditional right to make a back-up denial, "unencumbered by the doctrines of res judicata." As relevant, amended ORS 656.262(6) provides:

> "(6) Written notice of acceptance or denial shall be furnished to the claimant * * * within 90 days after the employer has notice or knowledge of the claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable * * * the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial."

We conclude that amended ORS 656.262(6) operates to permit SAIF to issue its "back-up" denial. As noted by the Court in Drews, supra, claim preclusion rules are subject to exception by statute. Drews, supra at 141. Although not expressly dealing with res judicata situations, ORS 656.262(6) expresses a clear legislative intent to allow "back-up" denials where a claim has previously been accepted, subject only to those limitations expressly set forth in the statute. We hold that the statute controls our resolution of this issue.

Here, SAIF initially denied the claim on June 30, 1989. At the time of its denial, it appears that the only evidence SAIF had regarding compensability was a brief statement from claimant's treating physician that the physician was not certain whether claimant contracted her disease at work. On November 27, 1989, SAIF received from claimant a further report from her treating physician supporting compensability of the claim. (Ex. 3). Prior to the commencement of the December 8, 1989 hearing, SAIF rescinded its denial and accepted the claim. Under such circumstances, we conclude that SAIF's acceptance was "in good faith." SAIF subsequently denied the claim less than two years after its "good faith" acceptance. Therefore, SAIF's denial was procedurally proper under ORS 656.262(6).

In reaching this conclusion, we take exception to the dissent's contention that a claim must be accepted by the carrier within 90 days of notice of the

claim in order to be considered accepted "in good faith" within the meaning of ORS 656.262. To begin, the second sentence of the statute expressly permits a carrier to revoke its "good faith" acceptance and issue a formal denial at any time up to two years from the date of the claim's acceptance. The focus of this provision is on an acceptance "in good faith," not on whether this acceptance was furnished to the worker within 90 days of the employer's notice or knowledge of the claim. It is the preceding sentence of the statute which sets forth the "90-day" processing requirement for issuance of the written notice of acceptance or denial of the claim. The second sentence contains no such limitation on an acceptance furnished "in good faith."

The dissent finds that the legislative history is clear in support of an interpretation that an acceptance is "in good faith" only when it occurs "within 90 days of notice or knowledge of the claim." We are unable to discern such an intent from the cited history. The testimony relied on by the dissent persuades us of two things: First, the 60-day period to accept or deny a claim was extended to 90 days in order to allow carriers to more fully evaluate a claim for benefits. It was hoped that more claims would be accepted as compensable if carriers were permitted a longer period of time to resolve questionable claims. See Kenneth A. Foster, 44 Van Natta 144 (1992). Second, carriers were to be allowed to issue "back-up" denials, even in the absence of fraud, under limited circumstances, including the requirement that the claim had been previously accepted "in good faith." See Anthony F. Ford, 44 Van Natta 240 (1992). Again, it was the hope of the legislature that carriers would be more willing to accept uncertain claims if they could subsequently "back-up" and deny the claim based on clear and convincing evidence that the claim was not compensable. The legislative history goes no further than this.

Further, the policy of encouraging claim acceptance would actually be frustrated by an interpretation that limited "good faith" acceptances to those occurring within 90 days of notice or knowledge. For example, in cases where expiration of the 90-day period was imminent, carriers would benefit from denying unclear claims and proceeding to a hearing -- with the burden on the claimant to establish compensability of the claim -- rather than accepting the claim and having the burden shift to them on a subsequent denial to establish noncompensability or lack of responsibility by clear and convincing evidence. By contrast, an interpretation which does not restrict a "good faith" acceptance to an acceptance with the 90-day period encourages acceptances at any point in the claim when the evidence supports compensability.

Moreover, in the event that the "90-day" requirement for acceptance or denial is exceeded, the statutory scheme provides for the imposition of penalties and, potentially, attorney fees should such conduct be found unreasonable. ORS 656.262(10); 656.382(1). We do not interpret the second sentence of ORS 656.262(6) in a manner that would effectively further penalize a dilatory carrier by restricting its "good faith" acceptance to a 90-day period. Instead, because the second sentence of the statute contains no limitation period for the "good faith" acceptance, we conclude that the opportunity to revoke such an acceptance is available to a carrier, regardless of whether the "good faith" acceptance occurs less than or more than 90 days from the employer's notice or knowledge of the claim. The dispositive inquiry is whether, under the facts of a given case, the acceptance has been "in good faith" regardless of whether the acceptance occurs within the 90-day period.

In conclusion, because we hold that res judicata does not preclude SAIF from issuing the "back-up" denial and because the Referee dismissed this matter without an evidentiary hearing, we remand this case to the Referee to convene a hearing. At that hearing, the parties shall have the opportunity to present evidence concerning the issues raised by SAIF's "back-up" denial. Specifically,

SAIF must prove by clear and convincing evidence that the claim is not compensable in order for its "back-up" denial to be valid. See ORS 656.262(6). Following that hearing, the Referee shall issue a final appealable order concerning this matter.

ORDER

The Referee's order dated May 29, 1991 is reversed and the case is remanded to Referee Quillinan for further proceedings consistent with this order.

Board Member Tenenbaum specially concurring.

I write to address the interpretation of ORS 656.262(6).

It is a basic premise of statutory construction that one does not look to legislative history if the meaning of the statutory language is clear on its face. In the case of many provisions of SB 1197, the Board has been faced with statutory language which is ambiguous, and we have often looked to the legislative history for guidance as to the legislature's intent. See, for example, Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991); Stanley Meyers, 43 Van Natta 2643 (1991); Raymond J. Seebach, 43 Van Natta 2687 (1991) and Anthony G. Ford, 44 Van Natta 240 (1992). In this case we sought that guidance as well.

I am constrained to agree with the majority that it is difficult to discern from the legislative history just what the legislature's intent was with respect to linking its efforts to encourage more claim acceptances to its grant of an opportunity for a back-up denial. I am not persuaded that the legislature intended the more restrictive interpretation put forward by the dissent, and concur with the majority's conclusion.

The dissent's interpretation of the statute, linking the availability of a back-up denial to a requirement that the claim be accepted within 90 days, would be a rational policy for the legislature to adopt. Including in the definition of a "good faith" acceptance those situations in which the carrier continues paying interim compensation beyond 90 days until it issues an acceptance, when its investigation is not complete within the 90 day period, would be another rational policy choice. However, the legislature did not clearly say that either.

For these reasons, I support the majority's conclusion.

Board Member Gunn dissenting.

I write to dissent from the majority's interpretation of ORS 656.262(6).

Amended ORS 656.262(6) provides:

> "(6) Written notice of acceptance or denial shall be furnished to the claimant * * * within 90 days after the employer has notice or knowledge of the claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable * * * the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial.***"

The issue is whether this provision for a back-up denial applies in a case where, as here, the carrier has not accepted the claim within the time allowed by law but has denied the claim, and following a request for hearing challenging the denial, has agreed to or been ordered to accept the claim.[1] For the reasons which follow, I would conclude that the option to issue a back-up denial is not available to an insurer in this position, and I would therefore declare the denial void and reinstate the claim acceptance.

The crux of the matter is the meaning of "accept[ance] of a claim in good faith." The term "good faith" is not defined and the expression could be subject to several interpretations, so I look to the legislative history to help determine the legislature's intent.

I first note that the amendment to section (6) increased from 60 to 90 days the time allowed to insurers to investigate claims and accept or deny them. The purpose of this change was explained in testimony to the Joint Interim Special Committee by representatives of both management and labor. It was clearly the intent of the Mahonia Hall Committee to increase the number of accepted claims by giving the insurer more time to investigate those claims, with the fall-back provision that if they accepted those claims within the 90 day period, the trade off would be leaving open the possibility of a back-up denial if their acceptance decision was discovered within two years to have been in error. Mr. Ross Dwinell, of United Grocers, explained:

> "* * * They must accept or defer or deny within 14 days and if defer they may go out to 90 days. The idea is that 60 days is a fairly short time frame and also represented actually a compromise on what we're going to talk about next and that's the reversal of the Bauman decision [.] * * * This allows for insurers or self-insured employers to back up and deny a claim that was first denied [sic] in good faith.***[2]
>
> * * *
>
> "So what has happened is that a number of insurers and self insured employers have denied claims because they know they can never turn around and deny them if evidence comes in on a later date. We felt that we had to deal with that and we would rather see claims accepted and at a later, and this caps at 2 years * * * if the evidence comes about within 2 years after the claim has been accepted and we've shifted the burden to the insurer to prove the claim is not compensable, then we're saying those back up denials will be sustained in those types of circumstances." Minutes, Joint Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 1, Side B, at 221.

This sentiment was affirmed by a labor representative, Mr. Cecil Tibbetts of Oregon AFCSME, who followed Mr. Dwinell, and stated:

> "* * * [W]e also changed the initial period for acceptance or denial of a claim from 60 to 90 days to give a little more time for

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[1] At the time this claim was processed, former ORS 656.262 provided a 60 day period for acceptance or denial; that period is now 90 days.

[2] I believe Mr. Dwinell misspoke himself; the only way for the sentence to make sense is to assume he meant to say that the provision allowed insurers to back up and deny a claim that was first accepted in good faith.

> the insurance company to take a look. What we're trying to do with these changes is create more acceptances and less denials that are really just nervous denials about the insurance company being concerned that they might later not want to accept this claim." Id. at 240.

That this was also the intent of the legislature is clear from the testimony of Representative Mannix before the House on May 7, 1990:

> "There is a provision that extends from 60 to 90 days the time in which a claim can be accepted or denied. This is important because today with time running out on conflict [sic] claims insurers often issue a denial on the 59[th] day. Not knowing for sure whether the claim should be denied but not wanting to take a chance. Why? Because if they go beyond 60 days they get hit with penalties. Now we'll say you now have up to 90 days.***" Floor debates, House of Representatives, May 7, 1990, Tape 2.

The very next sentence of Section (6), which contains the "good faith" reference, and begins with the word "however," provides that if the insurer "accepts a claim in good faith" but later finds evidence of noncompensability, it may issue a back-up denial. I believe that this reference to acceptance of a claim "in good faith" means a voluntary acceptance of the claim within 90 days. I believe this because the first and second sentences of section (6) are bridged by the word "however," and because that interpretation of the expression "accept in good faith" is most consistent with the legislative intent expressed. As Representative Mannix continued:

> "* * * Now we'll say you now have up to 90 days. Beyond that if you have accepted the claim as you should have in good faith but you come up with evidence that the claim was improperly accepted you can turn around and deny later on [.] * * * So there's a shift of burden against the employer if it wants to do a denial after these 90 days if it previously accepted the claim." Id.

The intent of the legislature was to encourage acceptances, and to acknowledge the risk of more good faith acceptances by allowing a limited back-up denial procedure.[3] An insurer which denies a claim in the first instance and forces the claimant to request a hearing to establish his or her claim, has not accepted the claim "in good faith," and was not the intended beneficiary of the

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[3] This legislative intent to encourage acceptances and to allow a limited back-up denial procedure is demonstrated by the testimony of Senator Grensky, who stated as follows:

> " "* * * [P]resently an insurer has 60 days to accept or deny a claim. The Bill in Section 15 extends this period to 90 days. The reason that the period of time to accept or deny a claim has been extended is because that under present law, employers are not able to * * * deny a claim once they have accepted it. The reason being that they're afraid to go ahead and accept it because they can't get those benefits back so this allows a 90 day period instead of the 60 day so that hopefully we'll have better claims evaluations and more incentives on the part of the insurer to accept the claim rather than just deny it and avoid those penalties in essence." Floor debate, Senate, May 7, 1990, Tape 4A.

option to issue a back-up denial. A good faith acceptance of a claim is one issued voluntarily, not under pressure of litigation, and within 90 days of notice or knowledge of the claim.[4]

This is so whether the claimant defeats the denial at hearing or in another final litigation order, or whether the carrier rescinds its denial sometime after a hearing is requested but before a final litigation order has issued. The insurer who does not accept the claim within the 90 days required by statute has not accepted the claim "in good faith," and may not thereafter issue a back-up denial in reliance upon ORS 656.262(6).

I am mindful that there may be occasions on which the insurer denies the claim for a legitimate reason and after the 90 day period accepts it. It has been argued that not allowing the insurer to issue a back-up denial in this kind of case would be an unfair punishment of the insurer. I disagree. I believe strongly that the opportunity to issue a back-up denial was a bonus, if you will, an "out" to be available to carriers in exchange for their satisfying the clear desire of the legislature that by extending the period to 90 days, more acceptances would be issued. The extension of the period for investigating claims was extended to 90 days to encourage acceptances, not "good faith denials."

I do not believe it fair to require a claimant to twice endure the expense and anxiety of requesting and preparing for a hearing. I recognize that there may be situations in which an insurer is precluded from issuing what might otherwise be a well-founded back-up denial because its original acceptance was not issued within 90 days. However, I am not a court of equity; only those rights and privileges exist which a statute specifically gives. Often that same principle works against claimants with legitimate claims or grievances who are "out of court" because they did not file a request for hearing or take some other action within a statutorily mandated time frame. The majority sees no linkage between the first and second sentences of ORS 656.262(6). I heartily disagree. I see such a linkage in the language, and I see such a linkage in the legislative history. I see this as a situation in which the legislature simply did not open the door as wide as the insurer would like it to be opened. One hopes the majority will be so liberal in their statutory interpretations the next time a worker with good cause doesn't file a claim until the 181st day.

In this case, SAIF initially denied the claim. Claimant challenged the denial, and on the day set for hearing, in lieu of litigation, SAIF rescinded the denial, leaving the question of attorneys fees (for counsel's efforts to set aside the denial) for the referee to decide. One and one-half years later, SAIF issued a back-up denial. SAIF's rescission of its denial at hearing, more than 60 days after the period for acceptance had expired, after claimant had retained counsel, requested a hearing and prepared for same, did not constitute an acceptance in good faith. In such circumstance, the statute does not provide a basis for a second, back-up denial. For these reasons, I conclude that SAIF's April 1991 denial was procedurally improper and should be set aside as void.

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[4] I do not suggest that a carrier who initially denies a claim but within the 90 day period rescinds the denial and accepts the claim would be barred from relying on this section to issue a back-up denial.

In the Matter of the Compensation of
JOHN H. BEMENT, Claimant
WCB Case No. 88-13391
ORDER ON REMAND
Quintin B. Estell, Claimant Attorney
Katherine Waldo, Assistant Attorney General

This matter is before the Board on remand from the Court of Appeals. SAIF v. Bement, 109 Or App 387 (1991). The court reversed our prior order, John H. Bement, 42 Van Natta 2335 (1990), which awarded claimant 10 percent unscheduled permanent disability when he had not suffered measurable permanent impairment. We had found that claimant would experience future exacerbations of his compensable condition that would result in temporary disability. Reasoning that claimant could not be compensated for such anticipated periods of temporary disability at the time of future aggravation claims, we concluded that claimant had "suffered a greater loss of earning capacity than is indicated by the standards" under former ORS 656.283(7). In reaching our conclusion, we relied on Gwynn v. SAIF, 304 Or 345 (1987), and International Paper Co. v. Turner, 91 Or App 91, rev den 307 Or 101 (1988).

The court determined that our interpretation of International Paper Co. v. Turner, supra, was too literal. Specifically, the court announced that it would not assume that an award was based on anticipated periods of temporary disability if, as a matter of law, the claimant was precluded from receiving benefits on the basis of that evidence. Inasmuch as claimant conceded that he had not suffered measurable impairment, and since such impairment was required for a permanent partial disability award under the "standards" (former OAR 436-35-320), the court held that we were precluded from awarding permanent partial disability. Consequently the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our October 11, 1991 Order on Review. We do not republish the "Findings of Ultimate Fact" contained in that order.

CONCLUSIONS OF LAW

As discussed in the opening paragraphs of this order, the court has held that we are precluded from awarding permanent partial disability. Consequently, in accordance with the court's opinion and for the reasons set forth above, we conclude that claimant is not entitled to a permanent partial disability award because he has not suffered measurable impairment. Former OAR 436-35-320.

In reaching this conclusion we are further assisted by the court's announcement that it will not assume that an award was based on anticipated periods of temporary disability if, as a matter of law, the claimant was precluded from receiving benefits on the basis of that evidence. Thus, since claimant is not entitled to a permanent partial disability award at the time of this claim evaluation, our finding that future exacerbations of claimant's compensable condition are anticipated will not preclude claimant from receiving additional benefits through future aggravation claims.

Inasmuch as our prior assumption that claimant would be precluded from receiving further benefits as a result of our finding of anticipated future exacerbations was inaccurate and since that assumption formed the basis of our award of permanent disability, we conclude that claimant has not established by clear and convincing evidence that his permanent disability is more than is indicated by the standards. Former ORS 656.283(7). Therefore, we hold that claimant is not entitled to an unscheduled permanent disability award.

Accordingly, on reconsideration, as supplemented herein, we affirm the Referee's order dated March 6, 1989.

IT IS SO ORDERED.

February 18, 1992 Cite as 44 Van Natta 270 (1992)

In the Matter of the Compensation of
JAMES V. COMPTON, Claimant
WCB Case No. 91-01201
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our January 29, 1992 Order on Review that awarded a $200 attorney fee for his counsel's services in obtaining payment of a medical services bill prior to hearing. Specifically, claimant requests an increased attorney fee for services rendered prior to hearing.

We agree with the SAIF Corporation that a minimal amount of time and effort was expended in this case. At hearing, the Referee provided claimant's counsel with an opportunity to submit a statement of services. However, claimant's counsel declined and stated that he had spent "between a couple and three hours" on this matter. (Tr. 7). Moreover, SAIF argues, and we agree, that claimant's counsel was also at hearing on a penalty issue, and the Referee subsequently awarded one-half of the penalty amount to claimant's counsel. Finally, we note that the compensation or interest to claimant in this case involved a medical services bill of $107.

Under the circumstances, after considering the factors set forth in OAR 438-15-010(4), we continue to conclude that $200 adequately compensates claimant's counsel for his services rendered prior to hearing.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, subject to the foregoing supplementation, we adhere to and republish our January 29, 1992 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 18, 1992 Cite as 44 Van Natta 270 (1992)

In the Matter of the Compensation of
DINAH S. DAVIS, Claimant
WCB Case No. 90-11855
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Podnar's order which upheld the self-insured employer's denial of claimant's claim for a left shoulder injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a 34 year old assembler. On Friday, April 27, 1990 at approximately 2:30 p.m. she was involved in a work-related discussion with her supervisor, Peterson, and another company supervisor, Cawood. During this discussion Cawood either pulled on claimant's left smock sleeve or on claimant's left arm. This incident occurred close to the end of claimant's shift. Cawood testified that he "reached over in a pinching motion and got hold of her jacket and tugged down." (Tr. 95). Claimant testified that Cawood pulled up suddenly on her arm so that her left foot came off the ground.

When claimant arrived home from work that evening, claimant's daughter observed blotchiness and red marks on claimant's arm. (Tr. 87). Claimant then telephoned Peterson and told Peterson that Cawood had hurt her and asked Peterson to tell Cawood not to do it again. (Tr 32). Claimant sought no medical attention that weekend.

On Monday, April 30, 1990, claimant made a complaint about the incident to the employer's human resources department. Claimant saw Dr. Holmes on Monday. Dr. Holmes' chart note states, "Patient stated that while at work on Friday 4/27 a supervisor, who is not her supervisor but works in some other area, came up and grabbed her in the area that she is describing, the deltoid region, grabbing her clothing and pinching the skin underneath." (Ex. 2a). Dr. Holmes noted no swelling or discoloration of claimant's arm.

Claimant was seen by the company doctor, Dr. Richardson, an osteopathic physician, on May 2, 1990. Dr. Richardson's chart note indicates that a supervisor grabbed claimant by the left shoulder/arm and picked her up. (Ex 3a). Dr. Richardson released claimant to modified work.

Dr. Holmes referred claimant to Dr. Thomas, orthopedist. Dr. Thomas saw claimant on May 8, 1990. Thomas related that a supervisor grabbed claimant by the left arm, picked her up by the left arm and shook her. (Ex. 5-1). Thomas felt claimant had a sprain and a tendinitis of the shoulder, and was also emotionally upset about the incident. Thomas took claimant off work for a week and sent her to physical therapy. The physical therapist's notes indicate that claimant was "involved in an altercation at work" during which a fellow employee "grabbed [claimant] by the left arm and twisted her arm." (Ex. 6a).

On May 15, 1990 Thomas wrote the employer requesting that claimant be evaluated by a pain clinic, or that claimant undergo psychological counseling. (Ex. 8). Thomas was concerned because he had anticipated that claimant would, by then, be much improved, but instead she appeared in emotional distress about the trauma she had suffered.

The claim was denied on May 23, 1990.

During his deposition, Dr. Holmes stated he had prescribed Motrin and Soma because he believed claimant was sore and uncomfortable. Holmes indicated that he prescribed Soma, a muscle relaxant, because he felt there was some muscle tightness. (Ex. 16-13).

In his deposition, Dr. Thomas indicated that when he evaluated claimant after the injury, he noted left shoulder and arm pain, limited range of motion in the neck, decreased range of motion in the left shoulder, tenderness over the muscles in the shoulder, and decreased grip strength. (Exs. 17-9, 10). Thomas diagnosed a strain and tendinitis of the shoulder.

Both Holmes and Thomas opined that if claimant's version of the incident were correct, then the incident was the major contributing cause of the injury. (Exs. 16-9; 17-4).

ULTIMATE FINDINGS OF FACT

Claimant had objective findings of an injury when examined by Drs. Holmes and Thomas.

The incident on April 27, 1990 was a material contributing cause of claimant's disability and need to seek medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had not established objective findings of an injury and had not established that an incident had occurred at work, as claimant had alleged. Therefore, the Referee found that claimant's claim was not compensable. We disagree.

Subsequent to the Referee's decision in this case, we issued our opinion in Suzanne Robertson, 43 Van Natta 1505 (1991). In Robertson, we held that in requiring "objective findings" in support of medical evidence, the legislature did not intend to exclude those findings based on an injured worker's subjective complaints. Rather, the intent was to require a determination by a physician, based on examination of the injured worker, that an injured worker has a disability or need for medical services. Such a finding may be based on a physically verifiable impairment, but, may also be based on the physician's evaluation of the worker's description of the pain she is experiencing. Id.

In this case, both Dr. Holmes and Dr. Thomas examined claimant and believed that she had suffered an injury to her left shoulder. Holmes stated that he had prescribed Motrin and Soma because he believed claimant was sore and uncomfortable. Holmes indicated that he prescribed Soma because he felt there was some muscle tightness.

Thomas noted left shoulder and arm pain, limited range of motion in the neck, decreased range of motion in the left shoulder, tenderness over the muscles in the shoulder, and decreased grip strength. Thomas believed claimant had suffered a strain and tendinitis of the shoulder.

Based on this evidence, we conclude that claimant has proven by medical evidence supported by objective findings that she suffered a shoulder injury.

Claimant must also prove that an injury arising out of and in the course of employment was a material contributing cause of her disability or need for medical treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

The Referee found the testimony of Peterson and Cawood more persuasive than that of claimant because claimant told the various physicians involved in this case "expanded" versions of the incident. Cawood admits tugging on claimant's sleeve, but denies that the incident was as severe as claimant contends. Peterson denies seeing any physical contact between claimant and Cawood. In exercising de novo review we generally defer to the Referee's determination of credibility, when it is based on the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360, 363 (1982). However, when the Referee's conclusion is based not on demeanor, but on an objective evaluation of the substance of a witness's testimony, we are in as good a position as the Referee to assess a witness' credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Davies v. Hanel Lumber Company, 67 Or App 35, 38 (1984).

We agree with the Referee's conclusion that claimant told somewhat embellished versions of the incident. However, it is undisputed that some type of physical contact between Cawood and claimant occurred. Claimant's physicians clearly believed she had sustained an injury and that injury was consistent with the incident as claimant described it to them. Furthermore, the Referee felt that the testimony of claimant's daughter was sincere. Claimant's daughter saw marks on claimant's arm the afternoon of the incident.

Although we believe that claimant's account of the incident was exaggerated, her story, reduced to its essence, is that Cawood grabbed and pulled on her arm with sufficient force to cause her shoulder injury. Cawood's testimony that an incident occurred supports this conclusion. Further, Peterson did not witness the incident. Finally, claimant reported the injury to her supervisor the afternoon it occurred. Based on these facts, we conclude that claimant has proven that her shoulder injury resulted from the grabbing and pulling incident on April 27, 1990 and that incident was a material contributing cause of claimant's disability and need for treatment.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,520 for services at hearing and $1,350 for services on review, for the total sum of $3,870, 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 appellant and reply briefs, statement of services and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated for his services.

ORDER

The Referee's order dated February 26, 1991 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on Board review, claimant's counsel is awarded $3,870 to be paid by the self-insured employer.

February 18, 1992 Cite as 44 Van Natta 273 (1992)

In the Matter of the Compensation of
CHRISTINE A. DeGRAUW, Claimant
WCB Case No. 90-18720
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Darryl Nelson, Defense Attorney

Claimant requests reconsideration of our January 21, 1991 Order on Review which concluded that we do not have jurisdiction over this matter until claimant first exhausts the administrative remedy as provided for in Section 48(3)(c) of Oregon Laws 1990 (Special Session), chapter 2. Claimant contends that the issue in this case was not accurately framed, and she asserts that an insurer cannot reclassify a claim from disabling to nondisabling.

In her request for reconsideration, claimant refers the Board to her prior arguments wherein she "extensively briefed" this issue. However, claimant's briefing of this issue consists of less than one full paragraph in which she asserts that the insurer's attempt to reclassify this claim is unlawful. Claimant has cited no authority for her contention. Nor are we aware of any authority in support of her position.

Under the circumstances, we conclude that the issue raised by claimant's request for reconsideration was adequately considered and addressed in our prior order, and we continue to conclude that we are without jurisdiction over this matter.

Accordingly, the request for reconsideration is granted. On reconsideration, as supplemented herein, we adhere to and republish our January 21, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SAM D. FERGUSON, Claimant
WCB Case No. 91-01766
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee McWilliams' order that set aside its denial of claimant's medical services claim for his right hand injury. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that this case is properly analyzed as a medical services issue under ORS 656.245, rather than as a consequence of a compensable injury under ORS 656.005(7)(a). We agree. Claimant did not seek benefits for a "new" compensable injury or disease, but rather he sought further medical treatment for his compensable carpal tunnel syndrome. The employer's denial stated that it was denying claimant's hospital treatment for his hand, but that claimant's right carpal tunnel condition remained accepted. Therefore, we analyze this matter as a medical services question under ORS 656.245.

At the outset, we find that, although the issue in the present case involves medical services, we have jurisdiction over this matter. In Michael A. Jaquay, 44 Van Natta 173 (1992), we held that there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical services. Accordingly, where a denial is based on the ground that the need for medical services is not causally related to the compensable injury, the Board has jurisdiction. Jaquay, supra.

An injured worker is entitled to medical services "for such period as the nature of the injury or the process of recovery requires, including such medical services as may be required after a determination of permanent disability." ORS 656.245(1)(a). In order to establish compensability of medical services, claimant must show that his compensable carpal tunnel condition (which includes the surgical incision resulting from the carpal tunnel surgery) is materially related to his current need for treatment.

We agree with the Referee that claimant has proven that his need for emergency room treatment was materially related to the compensable condition. See Van Blokland v. OHSU, 87 Or App 694 (1987). The evidence supports claimant's assertion that his need for treatment following his fall was materially related to his compensable condition, in that the surgical wound which was re-opened existed only because his compensable carpal tunnel syndrome required such surgery and the wound had not yet healed.

We also agree that Dr. Streitz's opinion that the emergency room treatment should be paid by claimant's private insurer should be given little weight, as it is an opinion on a legal matter, rather than a medical opinion regarding causation.

Under the circumstances, we agree with the Referee that claimant has proven that his accepted condition is materially related to his need for medical services in the form of emergency room treatment. Accordingly, we affirm the Referee.

Because the employer initiated the request for review and we have not disallowed or reduced claimant's compensation, claimant's counsel is entitled to an assessed fee under 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 $700 is a reasonable assessed fee for claimant's counsel's efforts concerning the issue of medical services, 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 June 3, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $700, to be paid by the self-insured employer.

In the Matter of the Compensation of
DANIEL L. GOFORTH, Claimant
WCB Case No. 91-02355
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation, on behalf of the noncomplying employer, requests review of Referee Mills' order that set aside its denial of claimant's hemorrhoid condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proven, by medical evidence supported by objective findings, that he had sustained a compensable injury in April 1990, which was a material contributing cause of his need for treatment of his hemorrhoid condition. We agree that, insofar as SAIF denied the occurrence

of a compensable injury in April 1990, that denial should be set aside. However, claimant has a preexisting hemorrhoid condition. SAIF's position at hearing was that claimant had a preexisting condition and work was not the major cause of his condition or current need for treatment.

Subsequent to the Referee's order, we determined that, under ORS 656.007(a)(B), where a claimant has a preexisting condition which combines with a compensable injury to cause or prolong disability or need for treatment, the claimant must establish that the compensable injury is the major contributing cause of the disability or need for medical services. Bahman M. Nazari, 43 Van Natta 2368 (1991). Therefore, although claimant has proven that there was a compensable injurious incident in April 1990, claimant must, under ORS 656.005(7)(a)(B), also prove by a preponderance of the evidence that the compensable April 1990 injury is the major contributing cause of his disability or need for medical services. Nazari, supra. We find that the causation of claimant's resulting hemorrhoid condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant's treating doctor, Dr. Denker, M.D., reported that:

> "It is my opinion that claimant's employment is a contributing factor and should be thought of as one of many factors that can cause a flare-up in his condition. I would not and do not feel that it is the major contributing factor to his flare-up."

Because there is no evidence to the contrary, we conclude that claimant's compensable April 1990 injury is not the major contributing cause of his disability and/or need for medical services. Accordingly, although claimant has established the occurrence of a compensable injury in April 1990, his resulting condition is not compensable.

The Referee assessed a $1,750 attorney fee for claimant's counsel's services at hearing. Because we are reinstating and upholding a portion of SAIF's denial, we conclude that the attorney fee at hearing should be modified. 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 at hearing in setting aside SAIF's denial of the April 1990 compensable injury is $750. Additionally, we find that a reasonable fee for claimant's counsel's services on review for successfully defending on the issue of the compensability of the April 1990 injury is $750, to be paid by SAIF. In reaching these conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 23, 1991 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the SAIF Corporation's denial insofar as it denied compensation for claimant's resulting hemorrhoid condition is reversed and that portion of SAIF's denial is reinstated and upheld. In lieu of the Referee's assessed attorney fee award, claimant's counsel is awarded a reasonable assessed fee for services at hearing and on review in the amount of $1,500, to be paid by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
CAROL C. JAURON, Claimant
WCB Case No. 90-10095
ORDER ON REVIEW
Ivan M. Karmel, Claimant Attorney
Thomas J. Castle (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

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

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's occupational disease claim was a claim for a worsened preexisting hypertension condition. The Referee further concluded that claimant had not established that employment conditions were the major contributing cause of the worsening of her hypertension.

On review, claimant contends that her occupational disease claim is compensable under several alternative theories. Claimant first claims that she has a psychological condition which arose out of the course of her employment. Alternatively, claimant contends that her mental stress is compensable as an occupational disease. Finally, claimant contends that her hypertension and diabetes conditions are compensable as physical conditions arising from stress at work. On review, we address each of claimant's theories separately.

Psychological condition

The Referee concluded that claimant did not suffer from a diagnosable mental disorder, as claimant's treating physician, Dr. Brookhart, M.D., in addition to independent medical examiners Drs. Klein and Turco, have all agreed that claimant does not suffer from a diagnosable mental disorder.

On review, claimant argues that Dr. Okulitch, Ph.D., who treated her following the 1988 auto accident, has diagnosed an emotional disorder. On January 29, 1991, Dr. Okulitch reported that he disagreed with Dr. Turco's opinion that there was no indication of a diagnosable psychological condition. Dr. Okulitch diagnosed claimant's condition as traumatic stress disorder.

Dr. Okulitch stated that claimant and her coworkers were under a general level of tension from the nature of the job. Additionally, he reported that, in claimant's case, the situation was exacerbated by a nonsupportive supervisor. He opined that the nature of claimant's job required consistency and reassurance from her immediate supervisor and he believed that claimant could return to work if she were to have a different supervisor.

We conclude that, even if claimant has a mental or emotional disorder which is generally recognized in the medical or psychological community, she has nevertheless failed to establish compensability of her condition pursuant to ORS 656.802. We have adopted the Referee's findings that claimant's problems at work arose from her interaction with Carol Smith. However, the Referee also found that Carol Smith did not directly supervise claimant, and some of the supervision attributed to Smith was actually due to actions or recommendations

made by Laura Flynn, claimant's immediate supervisor. We also agree with the Referee's conclusion that claimant mistakenly misperceived such actions and believed that they were part of a vendetta carried out by Carol Smith.

Under the circumstances, we conclude that the situation alleged by claimant did not exist in a real and objective sense. Moreover, Dr. Okulitch and Dr. Brookhart relied upon claimant's version of events in arriving at their opinion that claimant's psychological condition was due to a nonsupportive supervisor. See e.g. Leslie G. Brooks, 43 Van Natta 1834 (1991). Accordingly, we conclude that the medical opinions of Drs. Brookhart and Okulitch are insufficient to support a finding that real, objectively stressful events at work were the major cause of claimant's mental disorder. Claimant has not proven by clear and convincing evidence that work-related stressors are the major cause of her psychological condition.

Mental stress

Claimant contends that she has established that she has a work-related stress condition, as diagnosed by Dr. Brookhart and Dr. Klein. We disagree.

We have previously concluded 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) aff'd 108 Or App 499 (1991); Sharon Schettler, 42 Van Natta 2540 (1990). Accordingly, although Drs. Brookhart and Klein noted claimant's symptoms of stress, we do not find that such reports constitute a diagnosis recognized in the medical or psychological community.

Hypertension/diabetes

Claimant also argues that her hypertension and diabetes conditions are compensable as the conditions were worsened by work-related stress.

In Ronald V. Dickson, supra, we concluded that physical conditions resulting from work-related "stress" are not compensable unless a mental disorder has been diagnosed as the underlying condition. We have above concluded that claimant's symptoms of stress do not constitute a diagnosis generally recognized in the psychological or medical community. Moreover, we concluded that, even if Dr. Okulitch's report were construed as a diagnosis of a psychological condition, claimant has failed to establish that the particular employment conditions which produced her worsened hypertension and diabetes conditions were real, objectively stressful conditions. Thus, we conclude that claimant has failed to meet the requisites of ORS 656.802(1)(b). Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated May 8, 1991 is affirmed.

In the Matter of the Compensation of
EFREN G. QUINTERO, Claimant
WCB Case Nos. 90-11774, 90-11773 & 90-11772
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney
Larry Dawson, PC, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Peterson's order which: (1) upheld Old Homeplace Nursery/SAIF Corporation's denial of claimant's occupational disease claim for a low back condition; (2) upheld Old Homeplace Nursery/SAIF Corporation's denial of claimant's aggravation claim for a low back condition; and (3) upheld Don Schmidt Nursery/Country Companies' denial of claimant's low back condition. Don Schmidt Nursery/Country Companies have moved to strike claimant's appellant's brief as untimely. On review, the issues are compensability, responsibility, aggravation and motion to strike. We deny the motion to strike and affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the finding that claimant has had low back pain since a 1977 fall from a fruit tree and except for the last two sentences of the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Don Schmidt Nursery/Country Companies moves that we strike claimant's brief on the basis that it was not timely filed. We disagree. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. OAR 438-05-046(1)(c). Claimant's appellant's brief was mailed by certified mail on the date it was due. Therefore, we conclude that the appellant's brief was timely mailed. The motion to strike claimant's appellant's brief is denied.

Applicable Law

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

Compensability of Occupational Disease Claim

The Referee concluded that claimant had not established the existence of an occupational disease or a worsening of a preexisting disease by medical evidence supported by objective findings. ORS 656.802. We agree.

Dr. Aversano opined that although the precipitating cause of claimant's current back condition was the 1979 injury, the major contributing cause of claimant's current back condition is the heavy manual labor claimant has performed his entire life which has caused a progressive degenerative condition in claimant's back. We find Dr. Aversano's opinion that claimant suffered from an occupational disease unpersuasive for two reasons. First, there is no evidence that claimant suffers from a degenerative condition as Dr. Aversano believed. X-rays showed no sign of a degenerative condition and Dr. Coletti persuasively opined that there is no basis for concluding that claimant has degenerative disc disease.

Second, it is clear that Dr. Aversano believed that claimant's first low back injury was his compensable 1979 injury. (Ex. 24). Dr. Aversano was apparently not informed of claimant's 1977 low back injury in which a sack of fruit fell on top of him after he fell six to ten feet from a tree. We do not find Dr. Aversano's opinion, which is based on an incorrect history, to be persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. Megyesi, chiropractor, also opined that claimant had sustained an occupational disease. Dr. Megyesi based his opinion, in part, on his erroneous belief that claimant suffers from degenerative disc disease. We conclude that claimant has not proven that he suffers from an occupational disease.

Compensability of "Aggravation" Claim Against Old Homeplace Nursery

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 22 (1989) rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

We adopt the Referee's finding that claimant has proven a worsened low back condition which is supported by objective findings (a CT scan).

We also agree with and adopt the Referee's conclusion that no medical opinion relates claimant's worsened low back condition to the May 8, 1987 injury at Homeplace Nursery. Therefore, we conclude that claimant has not proven a compensable aggravation of his 1987 low back injury.

Compensability of "Aggravation" Claim Against Don Schmidt Nursery

The Referee found claimant not credible based on the history claimant gave to Dr. Mandiberg. Therefore, he upheld Don Schmidt's denial.

Dr. Mandiberg indicates in his history that claimant had had low back pain ever since the 1977 injury where he fell from a fruit tree with his basket of fruit landing on top of him. When, as here, a credibility finding is not based on demeanor, we are in as good a position as was the Referee to evaluate a witness' truthfulness and reliability. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). After reviewing the record we do not agree with the Referee's credibility determination and his conclusion based on that determination. Only Dr. Mandiberg's history indicates that claimant has had pain in his back since 1977. In light of other medical evidence in the record, we do not find the history recited in Mandiberg's report to be damaging to claimant's credibility and fatal to his claim.

Several medical opinions connect claimant's current back condition with his 1979 compensable injury at Don Schmidt Nursery. Dr. Fuller, orthopedic surgeon, and Dr. Peterson, neurologist, opined that claimant "probably sustained a major injury in 1979 and that this has followed the natural history of such conditions with slow aggravation over the years. Undoubtedly, repetitive bending and lifting have contributed to this condition over the years in his various jobs, but still the major part would appear to be his initial injury from which he never fully recovered and from which he always complained of back pain." We find the opinion of Dr. Fuller and Dr. Peterson to be well reasoned and based on complete information. We, therefore, find it persuasive. Somers v. SAIF, 77 Or App 259 (1986).

Dr. Aversano, osteopathic physician, also pointed to claimant's 1979 injury. He opined that claimant first injured his back significantly in 1979. He further opined that the heavy manual labor claimant has done all of his life led to a progressive degenerative condition in an already weakened back.

Dr. Coletti of Medical Consultants Northwest, a specialist in orthopedics, also opined that claimant's current condition is primarily the result of the 1979 injury. (Ex 35C).

Dr. Megyesi also opined that the precipitating cause of claimant's problem was the 1979 injury.

Accordingly, we find that claimant has established that claimant's current low back condition is causally related to his 1979 injury. We note that claimant's aggravation rights with regard to the 1979 compensable injury have expired. Therefore, his aggravation claim is subject to our "own motion" jurisdiction. ORS 656.278(1).

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing on the compensability/aggravation issue. 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 attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,750, to be paid by Country Companies. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 11, 1991 is affirmed in part and reversed in part. That portion of the Referee's order which upheld Country Companies' denial is reversed. Country Companies denial is set aside and the claim is remanded to Country Companies for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the aggravation issue, claimant's counsel is awarded an assessed attorney fee of $2,750, payable by Country Companies.

In the Matter of the Compensation of
PATRICK E. RILEY, Claimant
WCB Case No. 90-15318
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Otto's order which: (1) found that the Hearings Division had jurisdiction over a dispute concerning the interpretation of a Stipulated Order; (2) set aside a "de facto" denial of treatment by a psychologist; and (3) awarded an assessed attorney fee with respect to the denial of medical services. On review, the issues are jurisdiction, medical services and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Jurisdiction

The Referee found that the Hearings Division had jurisdiction over the question of claimant's entitlement to medical services because he found that: (1) the provisions of ORS 656.245(1)(b), concerning palliative care, did not provide claimant with a procedure for resolving a dispute concerning that care; and (2) the provisions of ORS 656.327(1)(a), concerning certain medical services disputes, were permissive rather than mandatory. The Referee also found that the treatment by Dr. Ballering, a psychologist, was reasonable and necessary. Although we agree that the Hearings Division has jurisdiction, we do so for different reasons. Furthermore, we find that the issue of the reasonableness and necessity of the psychologist's sessions was not raised by the parties and need not be addressed in this case.

Pursuant to ORS 656.704(3)[1], "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. The employer argues that ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." Thus, the employer argues, the Hearings Division lacks jurisdiction in this case.

We would agree with the employer's argument if either the employer or claimant had made such allegations about the psychotherapy treatments provided by Dr. Ballering. See Stanley Meyers, 43 Van Natta 2643 (1991). However, neither the employer nor claimant alleged that Dr. Ballering's psychotherapy treatments were "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

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1 ORS 656.704(3) provides:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining the procedure for the conduct and review thereof, matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter."

Rather than disputing the reasonableness or appropriateness of the treatment provided by Dr. Ballering, the employer argues, both at hearing and on review, solely that the psychotherapy provided by Dr. Ballering, a psychologist, is not compensable under the plain terms of the Stipulated Order. Thus, the issue here concerns the meaning and appropriate application of a stipulated order, i.e., an enforcement dispute. The Board, and thus the Hearings Division, has jurisdiction to enforce settlement stipulations. See Kevin A. Haines, 43 Van Natta 1041 (1991).

In Haines, we found that, in regard to vocational assistance, "where a worker and an insurer, or self-insured employer, enter into a stipulation whereby the insurer will provide specified vocational services without regard to the statute or the administrative rules, a party seeking enforcement of the stipulation need not first apply to the Director for administrative review." Kevin A. Haines, supra at 1044. However, in Haines, the stipulation authorized the insurer to discontinue vocational services when appropriate under "the rules governing vocational assistance." Because the dispute concerned the appropriate application of the Director's administrative rules, we found that the claimant could not invoke the jurisdiction of the Hearings Division before seeking administrative review by the Director, notwithstanding that the Board generally has jurisdiction to enforce stipulated settlements.

Here, the stipulated order provides that "claimant shall treat with a psychiatrist for the mental portion of this claim." (Ex. 36A-1). Unlike in Haines, however, the stipulation in the present case makes no reference to any statute or administrative rule. Rather, the dispute solely concerns the meaning and appropriate application of the Stipulated Order's terms. There being no procedure otherwise provided in ORS Chapter 656 for resolving this dispute, we find that the Hearings Division had jurisdiction to enforce this stipulation.

Medical Services

We adopt the Referee's reasoning and conclusion that the clear language of the stipulation does not limit claimant's treatment to that provided exclusively by a psychiatrist. Claimant abided by the provisions of the stipulation and sought treatment from a psychiatrist, Dr. Dixon. Dr. Dixon provided treatment and recommended that claimant continue his psychotherapy sessions with Dr. Ballering, a psychologist.

Moreover, the employer cites no evidence in the record supporting its argument that treatment is limited exclusively to that provided by a psychiatrist, and we can find none. The record does not reveal the existence of any dispute prior to the stipulation regarding the treatment provided by the psychologist, and there was no denial of compensability of that treatment.

Attorney Fees at Hearing

The Referee awarded claimant's attorney an assessed fee of $1,900 for services at hearing. The employer contends that this award is excessive. We disagree.

OAR 438-15-010(4) sets forth the following factors to be considered in determining a reasonable fee: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorney; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

After review of the record at hearing, and considering the above factors, we conclude that the Referee's award is reasonable. In reaching this conclusion, we have particularly considered the value of the interest involved, and the risk that counsel's efforts might go uncompensated.

Attorney Fees on Review

In arriving at a reasonable assessed fee at the Board level, we consider the same factors as above. However, we note that a portion of claimant's counsel's efforts was expended defending against the employer's effort to reduce the assessed fee awarded at hearing. No assessed fee is payable for such efforts. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). With this in mind, and considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the jurisdiction and medical services issues is $1,000. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's statement of services and brief) and the value of the interest involved.

ORDER

The Referee's order dated January 29, 1991 is affirmed. For services on review concerning the jurisdiction and medical services issues, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
RUSSELL A. WOLFER, Claimant
WCB Case No. 90-06471
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Thye's order that declined to award a carrier-paid attorney fee for claimant's counsel's services in connection with the pre-hearing rescission of alleged de facto partial denials of claims for low back, right hip, right gastrocnemius and right soleus muscle strains. On review, the sole issue is attorney fees. We reverse.

FINDINGS OF FACT

The insurer had notice or knowledge of claimant's claim for right gastrocnemius and soleus muscle strains by May 25, 1990. It had notice or knowledge of claimant's claims for right hip and low back strains by August 28, 1990. The claims for right hip, low back and right gastrocnemius and soleus muscle strains were neither accepted nor denied within 90 days of the insurer's knowledge of them. Pursuant to a March 27, 1991 Stipulated Settlement and Order of Dismissal, the parties agreed that the claims for all four strains had been accepted prior to the December 3, 1990 hearing date.

The hearing first convened on June 25, 1990.

CONCLUSIONS OF LAW AND OPINION

Preliminary matters

We note that, except for the March 27, 1991 Stipulation and "exhibits 1-4 attached thereto" received into evidence by the Opinion and Order, no exhibits were formally received. However, the Referee referred to evidence contained in Exhibits 1-43, 27A, 27B, and 31A-I and the parties' arguments refer to the presence or absence of such evidence. All the exhibits listed as intended to be received are included in the record as certified by the Referee to us under ORS 656.295(3). There are no evidentiary objections in the record. Accordingly, we conclude that the Referee intended to admit, and implicitly did admit, all exhibits offered by the parties. See Nellie M. Ledbetter, 43 Van Natta 570, 571 (1991).

Therefore, we consider all the exhibits as a part of the record for purposes of our review. ORS 656.295(5).

The Referee found that, even if claimant's low back, right hip, gastrocnemius and soleus muscle strains had been claimed and denied, claimant is not entitled to an assessed attorney fee because he did not prevail on the denials "in a hearing before a Referee," citing Duane L. Jones, 42 Van Natta 875 (1990). See former ORS 656.386(1). We disagree.

The Board's Jones decision was initially affirmed by the Court of Appeals. Jones v. Oregon State Correctional Institution, 107 Or App 78 (1991). However, Oregon Laws 1991, chapter 312, section 1, amended ORS 656.386(1), effective June 19, 1991 to provide that "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held, a reasonable attorney fee shall be allowed." Section 3 states that the amendments "apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury." Relying on the enactment of Oregon Laws 1991, chapter 312, the Jones court reconsidered its earlier opinion, reversed the Board's order, and remanded for the award of an attorney fee. Jones v. Oregon State Correctional Institution, 108 Or App 230 (1991).

In the present case, because the matter did not become final prior to the June 19, 1991 effective date of the amendments to ORS 656.386(1), the amendments are applicable. Therefore, we proceed to consider whether claimant's counsel's efforts were instrumental in obtaining compensation for claimant. ORS 656.386(1).

At the outset, we note that the insurer contends that it never denied the disputed claims. Therefore, it argues that claimant is not entitled to an attorney fee under ORS 656.386(1), because there is no "rejected" case. We disagree.

Under former ORS 656.262(6), the insurer was required to accept or deny a claim within 60 days of notice or knowledge of the claim. Effective July 1, 1990, ORS 656.262(6) was amended to allow an insurer 90 days to accept or deny the claim. See Or Laws 1990 (Special Session), ch. 2, 15. The claim is deemed denied de facto if the insurer has neither accepted nor denied the claim within the applicable claim processing period.. Barr v. EBI Companies, 88 Or App 132, 143 (1987).

In the present case, the insurer's date stamps establish that it had knowledge of claimant's claim for right gastrocnemius and soleus muscle strains by May 25, 1990 (see Ex. 26), and notice of claimant's claim for low back and right hip strains by August 28, 1990 (see Ex. 35). On this evidence, we

conclude that claims were made for the above mentioned four muscle strains. See ORS 656.005(6). There is no indication that the insurer accepted or denied these claims prior to the expiration of the applicable claim processing period, whether it was 60 or 90 days from notice of the claim. Therefore, the claims were denied de facto and they were "rejected" cases within the meaning of ORS 656.386(1).

Moreover, considering claimant's counsel's efforts in submitting hearing requests concerning the insurer's de facto denial of his low back and right hip claims and in light of his counsel's efforts in eliciting medical reports concerning claimant's various muscle strains and their relationships to his work activities, we conclude that claimant's counsel was instrumental in obtaining compensation for claimant through the rescission of the insurer's de facto denials, even though no hearing was held. Therefore, we hold that claimant is entitled to a carrier-paid attorney fee under revised 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 attorney fee for claimant's counsel's services prior to hearing concerning the de facto denials of his claims for low back, right hip and right gastrocnemius and soleus muscle strains is $1,300, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the case, and the value to claimant of the interest involved.

ORDER

The Referee's order dated April 3, 1991 is reversed. Claimant's attorney is awarded a reasonable assessed fee of $1,300, payable by the insurer.

February 18, 1992 Cite as 44 Van Natta 286 (1992)

In the Matter of the Compensation of
JOHN C. WOOD, Claimant
WCB Case Nos. 88-20635, 89-01336, 89-01337, 89-06777, 89-01338, 89-06778 & 89-01870
ORDER ON REVIEW
Max Rae, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Cummins, et al., Defense Attorneys
David Fowler (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Davis & Bostwick, Defense Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Emerson's order, for Referee Michael Johnson, that: (1) upheld the SAIF Corporation's denial, on behalf of Angell Transportation (an alleged noncomplying employer), of claimant's claim for a left shoulder injury; (2) upheld Safeco Insurance Company's denial, on behalf of Camas Transport, of the same injury; and (3) upheld UAC's denial, on behalf of Rollins Transport, of claimant's aggravation claim for his accepted left shoulder injury. In its brief, UAC contends that, if claimant is exempted from Oregon workers' compensation coverage pursuant to ORS 656.126(2), claimant cannot establish his aggravation claim against UAC's insured. On review, the issues are jurisdiction, subjectivity, compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

We adopt the Referee's "Opinion and Conclusions" on the issue of jurisdiction, and we add the following supplementation.

Claimant asserts that several factors indicate that Angell is an Oregon business and he was an Oregon subject worker at the time of the October 4, 1988 incident. We agree with claimant that there is no single factor that determines whether he is an Oregon worker. See e.g. Power Master, Inc. v. Blanchard, 103 Or App 467 (1990). However, we find that the Referee based his conclusion upon the fact that Angell Transport, although tied to an Oregon company through various brokerage and management agreements, existed as a separate Washington corporation with assets, liabilities and management separate from the Oregon company. We agree with the Referee that Angell is a separate, Washington corporation.

Moreover, the court in Power Master noted that it had previously reiterated that the "key inquiry" under ORS 656.126(1) is the extent to which the claimant's work outside the state is temporary. Power Master, Inc., supra; Hobson v. Ore Dressing, Inc., 87 Or App 397, 400 rev den 304 Or 437 (1987). In Power Master, the court found that a worker's trips to Washington were incidental and claimant's principal work continued to be in Oregon for his Oregon corporate employer. Accordingly, the court concluded that the claimant remained an Oregon employee for purposes of ORS 656.126(1).
Power Master, supra.

In the present case, however, the Referee concluded that, although claimant was in Oregon at the time he reported a worsening of his symptoms, the majority of claimant's work was outside of the state. The Referee specifically found, and we agree, that claimant was only temporarily in Oregon doing work for the employer.

Accordingly, we conclude that, although claimant was an Oregon resident, the majority of his work as a truck driver was performed in the states of Washington and California for a Washington state corporation. There is no evidence that his work within the state of Oregon was anything more than temporary. We therefore agree with the Referee that, as a "worker from another state" temporarily working in Oregon, claimant is exempted from coverage under Oregon's workers' compensation law by ORS 656.126(2).

Subjectivity

We affirm the Referee on the issue of subjectivity.

Compensability

Claimant alternatively contends that UAC, on behalf of Rollins Transport, is responsible for his current left shoulder condition. UAC argues that, if we uphold the Referee's finding that claimant is exempted from Oregon workers' compensation coverage pursuant to ORS 656.126(2), then claimant is precluded from establishing an aggravation claim under ORS 656.273. We disagree with UAC's contention.

In Miville v. SAIF, 76 Or App 603 (1985), the claimant was a worker with an accepted Oregon injury who suffered a worsening while working for an out-of-state employer. The court concluded that, if a claimant files an out-of-state claim and no compensation is awarded, then the claimant is entitled to Oregon compensation if the medical evidence shows that the original Oregon injury

materially contributed independently to the present disability. Miville v. SAIF, supra.

In the present case, claimant filed a Washington claim but received no compensation. However, the Referee found, and we agree, that claimant has not established that his 1987 injury with UAC's insured materially contributed to his present left shoulder condition. Accordingly, we affirm the Referee on this issue of compensability.

Responsibility

We have above found that claimant has not established a compensable claim against UAC. Moreover, we have further found that Angell Transport is exempt from Oregon workers' compensation laws and claimant was not a subject worker of Camas Transport. Accordingly, we do not reach the issue of responsibility.

ORDER

The Referee's order dated July 23, 1990 is affirmed.

February 19, 1992 Cite as 44 Van Natta 288 (1992)

In the Matter of the Compensation of
OSCAR L. COMPTON, Claimant
WCB Case No. TP-91025
THIRD PARTY DISTRIBUTION ORDER
Hollander & Lebenbaum, Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board to resolve a dispute concerning whether SAIF is entitled to a share of a judgment claimant has recovered stemming from injuries she sustained as a result of a non-work-related motor vehicle accident which occurred while claimant's compensable injury claim was in open status. Contending that no portion of the judgment was granted for disability or medical expenses resulting from the compensable injury, claimant asserts that SAIF is not entitled to a share of the recovery. We agree with claimant's contentions.

FINDINGS OF FACT

On August 18, 1987, while performing his work activities as a building washer, claimant fell from a scaffolding 8 to 8 1/2 feet to the ground. Claimant sought emergency room treatment. X-rays revealed fractures to the right fifth and seventh ribs as well as a segmental fracture of the right clavicle. Claimant was hospitalized from August 18, 1987 to August 23, 1987 as a result of these injuries.

On October 19, 1987, SAIF, the employer's insurer, accepted claimant's injury claim. In mid-October 1987, claimant began treating with Dr. Powers, chiropractor, who had treated claimant prior to the injury for low back pain. Claimant did not return to work following the injury and continued treatment with Dr. Powers.

In March 1988, claimant was examined by Dr. Kaesche, orthopedist. Dr. Kaesche diagnosed a fractured right clavicle with additional symptoms from the acromioclavicular joint as well as a probable tear of the right shoulder rotator cuff. Dr. Kaesche also noted that claimant had left upper extremity radiculopathy involving the C6-7 disc. Dr. Kaesche opined that claimant was not medically

stationary, and recommended possible surgical procedures involving the neck and left shoulder.

Thereafter, claimant sought a second opinion from Dr. Mandiberg, orthopedist. Dr. Mandiberg ordered an arthrogram of the right shoulder which was interpreted as normal. Claimant also underwent an MRI of the cervical spine which showed mild degenerative disc disease at C5-6 with cervical spondylosis right C5 and moderate narrowing of the right C5-6 neuroformina. Dr. Mandiberg injected the right submacromial bursa and sent claimant back to physical therapy. On June 27, 1988, Dr. Mandiberg reported that claimant could perform a modified job with no overhead work.

In August 1988, claimant underwent an electromyography and nerve conduction studies for hand symptoms. Although the EMG was negative, the nerve conduction studies indicated marked abnormalities in both the right and left ulnar nerves at the elbow. In September 1988, Dr. Mandiberg related claimant's hand symptoms to the industrial injury and opined that claimant's hand condition was not medically stationary.

On January 13, 1989, claimant sought treatment from Dr. Worthington, psychologist. Dr. Worthington diagnosed depression, secondary to the compensable injury and began a course of psychotherapy which continued through 1990.

On January 19, 1989, claimant was examined by the Western Medical Consultants. The Consultants reported that claimant was not medically stationary at that time. The Consultants recommended that claimant undergo clavicle resection surgery and a right shoulder acromioplasty, but reported that claimant was disinclined to have any invasive intervention at that time. The Consultants concluded that claimant could not return to his at-injury work and that continued chiropractic treatment was helpful.

On April 14, 1989, claimant was involved in a non-work-related motor vehicle accident when the car he was operating was struck from behind by a vehicle driven by a third party. Claimant was examined by Dr. Powers two days after the accident. Dr. Powers reported that the accident had increased claimant's neck and shoulder symptoms and caused low back pain. Dr. Powers opined that it was difficult to distinguish the cause of claimant's current symptoms, but indicated that the larger percentage of symptoms were due to the motor vehicle accident. However, Dr. Powers also indicated that claimant was not medically stationary at the time of the accident and opined that the compensable injury was also a major factor to consider in regard to claimant's symptoms. Dr. Powers recommended that claimant not participate in vocational training due to his aggravated physical condition.

On April 24, 1989, SAIF informed claimant that vocational assistance was ending on the basis that he was physically unable to participate in the vocational training. During this time, claimant continued to receive psychological treatment from Dr. Worthington. Dr. Worthington's treatment was related to the compensable injury and not to the motor vehicle accident.

On September 5, 1989, claimant was again examined by the Western Medical Consultants. The Consultants diagnosed cervical, thoracic and lumbar strains, but indicated that claimant's symptoms were similar to those exhibited during their January 1989 examination. The Consultants reported that claimant's permanent impairment had not changed and based on the objective evidence on examination and x-ray opined that claimant did not sustain a new injury as a result of the motor vehicle accident. The Consultants concluded that the motor vehicle accident had changed claimant's symptoms, but had not materially worsened his condition.

On September 12, 1989, SAIF denied responsibility for treatment of claimant's low back, thoracic and cervical strains on the basis that these conditions arose out of the motor vehicle accident. SAIF issued a further denial on October 11, 1989 based on the motor vehicle accident. Thereafter, claimant requested a hearing concerning SAIF's denials.

On November 15, 1989, Dr. Powers indicated that he did not concur with the Consultants September 5, 1989 report. Powers concluded that claimant's "cervical spine was most certainly re-injured and severely aggravated as a result of the auto accident of 4-15-89."

On November 17, 1989, Dr. Rodriguez reviewed the medical records regarding claimant's industrial injury and its relationship to the motor vehicle accident. Dr. Rodriguez opined that as a result of the motor vehicle accident, claimant had sustained soft tissue injuries superimposed on his prior injuries. Dr. Rodriguez found that only chiropractic treatment from April 17, 1989 through May 19, 1989 was attributable to the accident. All other care related to claimant's compensable injury. Dr. Rodriguez recommended a reimbursement of $1,100 for chiropractic care from April 17, 1989 through May 19, 1989.

On January 18, 1990, Dr. Powers opined that the automobile accident aggravated claimant's previous industrial condition, but that the greater percentage of claimant's disability related to the industrial injury. Dr. Powers concluded that the "auto accident caused a temporary worsening of the industrial condition based on the fact that [claimant's] symptoms and objective findings significantly increased immediately following the accident."

On February 27, 1990, the parties entered into a stipulation whereby SAIF rescinded its denials of September 12, 1989 and October 11, 1989. The stipulation acknowledged that claimant's accepted claim was for "multiple rib fractures and fractured clavicle." SAIF agreed to pay for claimant's "current medical care/treatment directly attributable to the accepted work related injuries."

Claimant's claim was closed by a June 7, 1991 Determination Order that found claimant medically stationary as of November 9, 1990. Additionally, claimant was awarded 18 percent unscheduled permanent disability.

Claimant has reached a settlement against the driver of the other vehicle involved in the April 1989 auto accident. Pursuant to that settlement, the third party insurer paid claimant the amount of $7,500. On November 11, 1991, Dr. Powers wrote SAIF a check in the amount of $1,100 for the purpose of reimbursing SAIF for treatment paid for by claimant's private insurer.

In December 1991, SAIF sought reimbursement for its claim costs. Contending that claimant's compensable injury had been exacerbated as a result of the April 1989 motor vehicle accident, SAIF asserted a lien of $7,682.19. Of that amount SAIF alleged that $4,858.54 was for temporary disability paid for the 90 days that claimant did not participate in a vocational rehabilitation program due to the motor vehicle accident. SAIF alleged that the remainder, $2,823.65, was for medical billings from Dr. Powers, Dr. Colistro and Vancouver Rehabilitation as well as mileage reimbursement to claimant. Dr. Colistro's billings were for psychological treatment unrelated to the motor vehicle accident.

When claimant contested SAIF's entitlement to a share of the settlement, SAIF petitioned the Board for resolution of the dispute.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy

against such third person, such worker shall elect whether to recover damages from the third person. ORS 656.578. The paying agency has a lien against the worker's cause of action as provided by ORS 656.591 to 656.593. ORS 656.580(2). An off-the-job injury that aggravates a compensable condition is a "compensable injury" within the meaning of ORS 656.578. SAIF v. Dooley, 107 Or App 287, 290 (1991).

In Dooley, the claimant was nearing a medically stationary status and still receiving temporary disability when he was involved in a motor vehicle accident unrelated to his employment. The accident resulted in new injuries and worsened the claimant's compensable condition. The claimant's physician was able to distinguish both the medical costs and the time loss attributable to the auto accident from those attributable to the original injury. As a paying agency, SAIF did not pay the medical costs resulting from the accident. However, SAIF sought reimbursement from the claimant's settlement with the third party for four months of additional temporary disability attributable to the worsened compensable condition. Reasoning that SAIF was obligated to pay the additional benefits for the aggravated compensable condition, the court held that SAIF was entitled to receive a share of the settlement proceeds.

Here, as in Dooley, claimant had not reached medically stationary status and he was still receiving temporary disability when he was injured in a motor vehicle accident unrelated to his employment. Also, as was the case in Dooley, the accident worsened some of claimant's compensable conditions. Nevertheless, unlike Dooley, the present record does not distinguish between the medical expenses and disability benefits attributable to the motor vehicle accident from those resulting from the original compensable injury. Without such evidence, we are unable to determine what, if any, portion of the compensation SAIF has provided is directly attributable to the April 1989 motor vehicle accident.

Following the motor vehicle accident, Dr. Powers reported that the accident had increased claimant's symptoms. He opined that a large percentage of the symptoms were due to the accident, but also stated that the compensable injury was a major factor to consider as claimant was not medically stationary at the time of the accident. In a later report, Dr. Powers reiterated his opinion that the accident had aggravated claimant's compensable condition, but stated that the greater percentage of claimant's disability was related to the compensable condition. Dr. Powers concluded that the motor vehicle accident caused a temporary worsening of claimant's compensable injury.

Western Medical Consultants opined that the accident had changed claimant's symptoms, but had not materially worsened his condition. Dr. Powers disagreed with the Consultants and stated that claimant's "cervical spine was most certainly re-injured and severely aggravated as a result of the auto accident of 4-15-89."

Dr. Rodriguez opined that claimant had sustained soft tissue injuries superimposed upon the compensable injuries. Dr. Rodriguez related claimant's chiropractic treatment from April 17, 1989 through May 19, 1989, to the motor vehicle accident.

We conclude that SAIF has not established that it incurred an additional amount of disability or medical services as a result of the motor vehicle accident. In reaching this conclusion, we rely on the opinion of Dr. Powers. Dr. Powers has treated claimant for the compensable injury since October 1987. Further, he saw claimant prior to and immediately following the motor vehicle accident. Because of his long term exposure to and knowledge of claimant's condition, we accord Dr. Powers' opinion the most weight. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Although Dr. Powers did not concur with the September 1989 report by the Western Medical Consultants, we find that the Consultants' opinion supports Dr. Powers' conclusion. Although the Consultants had examined claimant a few months prior to the motor vehicle accident they did not examine claimant again until five months after the motor vehicle accident at which time they reported that claimant's condition had not materially worsened, but noted a change in symptoms. This is consistent with Dr. Powers' conclusion that the motor vehicle accident caused a temporary worsening of claimant's compensable condition. Therefore, we do not interpret the Consultants' opinion to mean that the automobile accident did not affect claimant's compensable condition. Rather, we find that it supports the proposition that the motor vehicle accident and the compensable injury were both contributing factors to claimant's disability and need for medical treatment.

Finally, we do not rely on the opinion Dr. Rodriguez. Dr. Rodriguez did not exam claimant either before or after the motor vehicle accident, but merely reviewed the medical record. Further, Dr. Rodriguez's conclusion is based on his opinion that claimant sustained soft tissue injuries superimposed on the compensable condition. This opinion is not supported by either Dr. Powers or the Consultants, both of whom examined claimant. We, therefore, are not persuaded by the opinion of Dr. Rodriguez.

In conclusion, we are not persuaded that the April 1989 accident required SAIF to provide additional compensation that it would not have otherwise paid. Accordingly, we hold that SAIF is not entitled to a share of the proceeds from claimant's settlement stemming from his April 14, 1989 motor vehicle accident. See Calina Neathery, 43 Van Natta 2734 (1991).

IT IS SO ORDERED.

In the Matter of the Compensation of
DUNCAN B. CROSBY, Claimant
WCB Case No. 90-18059
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Leahy's order that: (1) increased claimant's scheduled permanent disability for the loss of use or function of his right forearm (hand) from 23 percent (34.5 degrees), as awarded by a prior Determination Order, to 28 percent (42 degrees); and (2) awarded 14 percent (21 degrees) scheduled permanent disability for loss of use or function of his left forearm (hand). In his respondent's brief, claimant asks that the Referee's 14 percent award for claimant's left forearm be increased to 19 percent. On review, the issue is extent of scheduled permanent disability.

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

The Referee increased claimant's total scheduled permanent disability in his right forearm from 23 percent to 28 percent, and awarded claimant 14 percent for his left forearm. In making that determination, the Referee included 5 percent for chronic condition limiting repetitive use of the right forearm and 14 percent for loss of grip strength in the left forearm. We agree.

On review, the insurer challenges the Referee's additional 5 percent award for claimant's right forearm as excessive, arguing that, under Stepp v. SAIF, 304 Or 375 (1987), claimant must prove that his condition has worsened. The insurer further argues that claimant is not entitled to an increased award because his right hand grip strength has actually improved. Here, we find that there is ample evidence in the record to support a worsening of claimant's right forearm condition.

In determining whether there is a worsening of claimant's right forearm condition, we compare his present condition with his condition at the time of the July 14, 1989 Determination Order. Just prior to the Determination Order, Dr. Nelson examined claimant and found that he had a "mild partial permanent impairment" of the right forearm as a result of his compensable injury. (Ex. 8-2). Since that time, claimant has had right carpal tunnel release surgery (Ex. 15), a right lateral epicondylectomy (Ex. 20-1) and a decompression of his right first dorsal compartment (Id.), all of which were authorized and paid for by the insurer. Moreover, claimant credibly testified at hearing that he continues to have shooting pain which increases with repetitive use of his right arm. (Tr. 25-26). In addition, he stated that he tried to work, but had to quit jobs after only a few days because of the pain. (Id). These complaints are documented in the medical record. We conclude based on this evidence that claimant has established a worsened condition of his right forearm, thereby entitling him to a further evaluation of his permanent disability attributable to his compensable condition.

After conducting our determination, we agree with the Referee that claimant has suffered a chronic condition limiting his repetitive use of his right forearm. Former OAR 436-35-010(7). Consequently, we affirm the Referee's order which increased claimant's scheduled permanent disability award for loss of use or function of his right forearm from 23 percent to 28 percent.

The Referee also awarded 14 percent for claimant's loss of grip strength due to median nerve impairment in the left forearm under former OAR 436-35-110(3). On review, the insurer contends that the July 24, 1990 grip strength of 110 pounds should be used instead because it was performed closest to the hearing. Here, we find Dr. Nathan's test, which was relied on by the Referee, more persuasive because it used three repetitions instead of one and, thus, gave a more persuasive account of claimant's reduced grip strength. Based on a comparison between Nathan's test and claimant's uncontested baseline, we agree with the Referee that a 14 percent award represents an appropriate measure of claimant's lost grip strength in the left forearm.

Additionally, claimant argues that he is entitled to 5 percent for chronic condition limiting repetitive use in the left forearm. The insurer responds that, under Temp. rule OAR 436-35-010(8), a 5 percent award for chronic condition is available only when claimant does not have a ratable impairment that exceeds 5 percent. However, that rule applies only to workers medically stationary after July 1, 1990. Since claimant was found medically stationary on May 21, 1990, the rule is inapplicable. (Ex. 26-5). Moreover, after considering the medical and lay evidence, we are not persuaded that claimant suffers from a chronic condition limiting the repetitive use of his left forearm. Consequently, we decline to award claimant an additional 5 percent scheduled permanent disability.

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under 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 is $612.50, to be paid

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

ORDER

The Referee's order dated June 6, 1991 is affirmed. For services rendered on review, claimant's counsel is awarded $612.50, to be paid by the insurer.

February 19, 1992 Cite as 44 Van Natta 294 (1992)

In the Matter of the Compensation of
VICKIE M. LIBEL, Claimant
WCB Case No. 91-01587
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Spangler's order that increased claimant's unscheduled permanent disability award for a low back and left hip injury from 13 percent (41.6 degrees), as awarded by a Determination Order, to 15 percent (48 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

ULTIMATE FINDINGS OF FACT

Claimant has 18 percent unscheduled permanent disability as a result of her April 1989 compensable injury.

CONCLUSIONS OF LAW AND OPINION

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). Evaluation of the worker's disability shall be as of the date the Reconsideration Order was issued pursuant to ORS 656.268. ORS 656.283(7).

We adopt the Referee's reasoning and conclusions regarding the values for age (1), formal education (1), skills (3), and impairment (5). We address only the adaptability value.

The Referee found that: (1) claimant's regular work at the time of injury was medium/heavy work; and (2) her modified work was light work. Using the table at former OAR 436-35-010(3)(d), the Referee concluded that claimant's adaptability value was 2. Claimant argues that her regular work should be classified as heavy work. We agree with claimant.

Former OAR 436-35-310(3) provides in pertinent part:

> "(a) For workers who are working at modified work at the time of determination, the factor of adaptability shall be based on the difference between the physical capacity necessary to perform the

regular work and the physical capacity necessary to perform the modified job according to the table in this section.

* * * *

"(d) Strength factors, for prior strength, are derived from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT), published by the U.S. Department of Labor, 1981. The SCODDOT describes the specific physical demands for each occupation listed in the Dictionary of Occupational Titles."

At the time of the January 31, 1991 Order on Reconsideration, claimant was working at modified work as a check weigher. Therefore, claimant's adaptability value is determined from a table of values at former OAR 436-35-010(3)(d). See former OAR 436-35-010(3)(a).

The clear language of former OAR 436-35-010(3)(d) requires that the prior strength factor be determined by reference to the SCODDOT. Here, claimant's regular work is a "material handler" (DOT No. 929.687-030). This work is classified as "very heavy" in the SCODDOT. Accordingly, we conclude that claimant's work was in the "heavy" category.

Claimant argues that, because she is limited to light work with restrictions on stooping, crouching, and twisting, her modified work has a sedentary/light strength requirement. We disagree. Former OAR 436-35-010(3)(d) does not factor restrictions into the strength requirements. Only if claimant was not working at the time of determination, would these restrictions be factored into her residual physical capacity. See former OAR 436-35-010(4) and (5).

Here, claimant's regular work required the physical capacity to do heavy work. Claimant's modified work required a light physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-010(3)(d).

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 4, the sum is 5. When that value is multiplied by claimant's adaptability value 2.5, the product is 12.5. When that value is added to claimant's impairment value 5, the result is 17.5 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 30, 1991, as corrected on June 6, 1991, is modified. In lieu of the Referee's award and in addition to the 13 percent (41.6 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving her a total award to date of 18 percent (57.6 degrees) unscheduled permanent disability for a low back and left hip injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
DARRELL A. SENTERS, Claimant
WCB Case No. 90-02349
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Black's order which upheld the self-insured employer's denial of claimant's injury claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings and supplement as follows.

Weather reports indicate that snow and sleet fell in early March 1989 in the Eugene area, but did not stick to the ground at Mahlon Sweet airport. (Ex. 123-2).

The groundskeeper at Lane Community College attested that snow and ice are often present at the campus when no snow or ice is present in Eugene. (Ex. 125).

ULTIMATE FINDINGS OF FACT

Claimant's slip on snow or gravel while participating in an authorized training program materially contributed to his need for treatment of his low back and his resulting disability.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing before May 1, 1990 and a hearing was convened before July 1, 1990, his claim is properly analyzed under the law as it existed prior to the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant was initially compensably injured in a 1985 logging accident, which involved a crush injury to his left hand and trauma to his neck. In April 1986 claimant was involved in a noncompensable motor vehicle accident, in which he was rear-ended by another vehicle. Claimant suffered an injury to his low back in this accident. In October 1988, Dr. Throop indicated that this low back injury had resolved. (Ex. 51). Claimant was involved in a second, less severe auto accident in 1986 in which he injured his left knee.

Claimant was eligible for vocational assistance as a result of his compensable 1985 injury. In early March 1989, while participating in an Authorized Training Program (ATP) at Lane Community College, claimant contends that he slipped on sand, gravel or melting snow on some steps, injuring his low back, and resulting in this claim.

The Referee noted that claimant's memory of the events surrounding the injury was vague and sketchy and that claimant's assertions about slipping on gravel or snow did not appear to be consistent with reports of weather conditions in Eugene around the dates of the injury. The Referee therefore concluded that claimant had not established that his low back injury was compensable. We disagree.

In order to establish the compensability of his low back condition, claimant must prove that the March 1989 incident at Lane Community College was a material contributing cause of his low back injury, and that the injury resulted in disability or the need for treatment. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Claimant has the burden of proving his contentions by a preponderance of the evidence. ORS 656.266; Hutcheson v. Weyerhaeuser, supra. Injuries sustained while participating in authorized training programs are compensable as direct and natural consequences of the original injury. See SAIF v. Partible, 98 Or App 244 (1989). After reviewing the record, we conclude that claimant has sustained his burden of proof.

The employer asks us to make a finding that claimant is not credible. The Referee found claimant's memory unreliable, but did not make a credibility finding based on his demeanor. In exercising de novo review, we generally defer to the Referee's determination of credibility, when it is based on the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360, 363 (1982). However, when the Referee's conclusion is based not on demeanor, but on an objective evaluation of the substance of a witness' testimony, we are in as good a position as the Referee to assess a witness' credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Davies v. Hanel Lumber Company, 67 Or App 35, 38 (1984).

After reviewing the record, we do not consider claimant to lack credibility. We base this conclusion on the following reasoning.

As a result of his March 1985 compensable injury, claimant suffers from myoclonus, a condition which causes tremors of the neck. To control claimant's tremors, Dr. Throop prescribed klonopin, a drug which, according to Dr. Throop, affects claimant's cognitive abilities and causes drowsiness. When these side-effects are considered along with the approximately 15 month delay between the March 1989 fall and the June 1990 hearing, we do not consider it significant that claimant's recollection at hearing of the conditions and circumstances existing at the time of his slip and fall was not as clear as it otherwise would be. Instead, in reaching our decision, we look to the contemporaneous medical record to determine whether claimant's low back condition is related to a fall during his participation in the ATP.

A March 9, 1989 chart note from Dr. Halpert states that claimant "slipped on sand on stairs at LCC last week." Dr. Halpert, a general practitioner, suspected a possible herniated lumbar disc and referred claimant to a neurosurgeon, Dr. Gallo. In her April 5, 1989 report, Dr. Gallo states, "While working at LCC, [claimant] slipped in the snow in March of this year and fell on some steps. About 2 days later, he had the onset of low back pain." A July 1989 myelogram and post myelogram C.T. revealed "a left L4-5 disc bulge or possibly small focal herniation which partially compresses the left L4 nerve root and may be significant."

The Referee took official notice that the campus where the injury occurred is at a higher elevation than the Eugene airport, where weather conditions for the city are recorded. Based on National Weather Service reports low temperatures in Eugene from the first of March to the fourth reached freezing, although the high temperatures were in the forties. Temperatures were above freezing for the rest of the month. (Ex. 121). The record also contains evidence that snow and sleet fell in the Eugene area in early March 1989. (Ex. 123-2). This is consistent with claimant's statements to both Dr. Gallo and Dr. Halpert. Although snow did not stick to the ground at the Eugene airport, the groundskeeper at Lane Community College states that there is often snow and ice at the college when there is none in Eugene. Based on these facts, we find it more likely than not that claimant did, in fact, slip on gravel, snow or sand during the time period in question.

The employer argues that claimant's low back problems result from his April 1986 motor vehicle accident. We do not find this argument persuasive. An October 11, 1988 report by Dr. Throop, the physician who treated claimant for the April 1986 motor vehicle injury, states, "In 1986 he did have an auto accident where he had low back pain which subsequently cleared. He has had no real difficulties since." (Ex. 51). On the basis of Dr. Throop's report, we conclude that claimant's 1986 noncompensable low back injury had resolved.

Accordingly, we conclude that claimant has sustained his burden to prove that his injury was a material contributing cause of his low back condition. Consequently, the employer's denial shall be set aside.

Claimant is entitled to an assessed attorney fee for services at hearing and on Board review for prevailing on the compensability issue. 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 attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated October 17, 1990 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded $3,500 to be paid by the employer.

In the Matter of the Compensation of
GERALD D. SPENCER, Claimant
Own Motion No. 66-0226M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our January 14, 1992 Own Motion Order that declined to reopen claimant's claim for medical services and temporary disability compensation. We abated our order on January 13, 1992 in order to allow sufficient time to consider the motion for reconsideration. Claimant requests an evidentiary hearing in order to establish his credibility.

Our denial of claimant's claim was not based on claimant's credibility or lack of the same. We made no credibility findings. Rather, we found the medical evidence insufficient to establish that claimant's 1990 cellulitis condition was a direct result of his 1963 injury rather than the burn diagnosed by Dr. Conner, claimant's treating physician, or if it was related to claimant's obesity or diabetes.

Claimant had an adequate opportunity to obtain an opinion regarding the cause of his 1990 condition from Drs. Buie and Stanton prior to our January 14, 1992 order. Claimant also had adequate opportunity to seek an opinion from Dr. Conner regarding his diagnosis of a burn on claimant's leg, which may have been the cause of the need for claimant's hospitalization in December 1990. We are accordingly unable to ascertain how a hearing to assess claimant's credibility would benefit our review of his 1990 request for own motion relief.

We accordingly deny claimant's request for an evidentiary hearing.

As a matter of clarification, we did not address the issue of claimant's current 1991 ulcer behind his right knee, as identified by the independent medical examiners, since that condition was not the one before us.

On reconsideration, claimant also presented a sworn affidavit pertaining to his job search prior to his hospitalization in November 1990 that supports his earlier contention that he had looked for work. We accept that affidavit and find that claimant was willing to work and was looking for work prior to his December 1990 hospitalization.

On reconsideration, as supplemented herein, we adhere to and republish our October 21, 1991 order. The parties' rights to reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

February 20, 1992 Cite as 44 Van Natta 299 (1992)

In the Matter of the Compensation of
RICHARD D. KATZENBACH, Claimant
WCB Case No. 90-13777
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Brown's order which: (1) admitted two medical reports (Exhibits 23 and 24) offered by the self-insured employer after the hearing was continued; and (2) upheld the employer's denial of claimant's occupational disease claim for a right shoulder condition. On review, the issues are the Referee's evidentiary ruling and compensability on the evidentiary issue.

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

Claimant contends that Exhibits 23 and 24 (medical reports from Dr. Corson) should be excluded as not timely offered. Claimant asserts that the specific purpose for the continuance was for the deposition of Dr. Potter and not for the employer to gather additional evidence. Consequently, claimant argues that the Referee erred by allowing Exhibits 23 and 24 (offered after the hearing while the record was still open) to be admitted. We disagree.

A Referee may continue a hearing upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden to obtain and present final rebuttal evidence. See OAR 438-06-091(3); David F. Grant, 42 Van Natta 865, 867 (1990). Further, OAR 438-06-091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within a Referee's discretion. Sue Bellucci, 41 Van Natta 1890 (1989); see Randy L. King, 38 Van Natta 1046 (1986). Further, ORS 656.283(7) provides that the Referee is not bound by common law or statutory rules of evidence.

Here, at the November 13, 1990 hearing, before proceeding to take testimony, the Referee announced that claimant's counsel wanted to cross-examine Dr. Potter, claimant's treating physician. This proposed cross-examination

concerned an exhibit which had been submitted into the record (apparently Dr. Potter's November 8, 1990 report concerning claimant's condition and its relationship to claimant's work activities). The Referee further announced that claimant's counsel had scheduled a deposition for Dr. Potter on January 10, 1991. Under such circumstances, the Referee ruled as follows: "Since it appears that this matter cannot be completed today, then it's necessary to continue the hearing until the deposition is completed, and for that reason, we won't be taking any testimony."

The continued hearing convened on January 23, 1991, at which time, the employer submitted Exhibits 23 and 24 which were reports authored by Dr. Corson who had reviewed claimant's medical record and a video tape of a dryer feeder job.

Claimant objected to these exhibits as not being timely obtained and prejudicial. (Tr. 2). The Referee denied the objection, reasoning that the hearing had not been continued nor had the record been left open solely for the deposition of Dr. Potter. In any event, the Referee offered to keep the record open to permit claimant to cross-examine Dr. Corson and/or obtain a further response from Dr. Potter. (Tr. 4). Although continuing to object to the Referee's ruling, claimant declined the opportunity, preferring to rely upon Dr. Potter's deposition.

Although the deposition of Dr. Potter was the focus of the Referee's discussion concerning the granting of a continuance, the Referee did not expressly hold the record open solely for that evidence. Moreover, since the Referee neither admitted exhibits nor took testimony at the first hearing, the record was not "frozen" but for the Potter deposition. Finally, the Referee granted claimant an opportunity to respond to the reports from Dr. Corson. See OAR 438-06-091(3). However, claimant declined to avail himself of this opportunity. Under such circumstances, we conclude that the Referee did not abuse his discretion by allowing Exhibits 23 and 24 to be admitted into evidence. See David F. Grant, supra; Randolph P. Gaul, 42 Van Natta 1171, 1172 (1990).

ORDER

The Referee's order dated March 21, 1991 is affirmed.

In the Matter of the Compensation of
BRIAN G. OVERALL, Claimant
WCB Case No. 90-17128
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Kathryn Wilske (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Tenenbaum and Gunn.

The SAIF Corporation requests review of Referee Fink's order that set aside its denial of claimant's right shoulder surgery request. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT" with the following exceptions. We find that the anatomical area involved in this injury included the right rhomboid muscle region at the lower medial scapula. At the time of this

industrial injury, claimant felt acute pain in this area only. We find that claimant is a poor historian with regard to recalling the onset of his symptoms, their severity and their location. Claimant has not proved a sufficient relationship between his injury and his worsened right acromioclavicular separation with subluxation and need for surgery.

On June 6, 1990, claimant began treating with Dr. Graham, orthopedic surgeon, for his continuing symptoms.

FINDINGS OF ULTIMATE FACT

SAIF's May 23, 1990 acceptance of claimant's 1990 industrial injury claim for a right rhomboid strain did not include claimant's right acromioclavicular (AC) joint condition, which is a separate condition.

Claimant's compensable injury combined with his preexisting AC joint condition, but the injury was not the major contributing cause of his disability and need for surgery.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's claim compensable. We reverse.

The hearing in this case convened after July 1, 1990. Therefore, the 1990 amendments to the relevant portions of the Workers' Compensation Law, Chapter 656, apply unless retroactive application of the law would produce an absurd or unjust result. Or Laws 1990 (Special Session), ch. 2, 54; see Ida M. Walker, 43 Van Natta 1402 (1991). We conclude the amendments apply in this case.

The insurer is required to provide medical services for conditions resulting from a compensable injury. ORS 656.245(1). Here, claimant had an accepted claim for a right rhomboid muscle strain. Claimant has requested benefits for surgery on the distal clavicle, a component of the right AC joint. SAIF denied the surgery, stating that the major contributing cause of the need for surgery was an off-the-job accident in 1983 and the normal progression of the resulting degenerative arthritis and joint disruption that was a direct result of that accident. Inasmuch as we find that the compensable injury combined with the preexisting shoulder condition to cause claimant's need for treatment, claimant must prove by a preponderance of the evidence that the compensable injury is and remains the major contributing cause of his need for treatment. ORS 656.005(7)(a)(B).

The Referee found claimant to be credible. SAIF contends that claimant is not a credible historian and that his lay testimony is insufficient to establish the necessary causal relationship in this medically complex case. When a Referee makes a specific finding on credibility based upon demeanor, as the Referee did in this case, we defer to the Referee. See Bush v. SAIF, 68 Or App 230, 233 (1984); Donald Hardiman, 35 Van Natta 664, 665 (1983). We do not go so far as to find claimant not to be credible, but based on the range of inconsistencies in the record, we agree that claimant is not a reliable historian, and his testimony is insufficient to establish a causal relationship in a medically complex case. Consequently, we rely on medical evidence to establish causation in this case. See 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).

In October 1983, claimant injured his right shoulder in a bicycle accident. He sustained a separation and subluxation of the AC joint. This joint is at the top of the shoulder between the acromion and clavicle. He came under the care of Michael Baskin, M.D., orthopedic surgeon. Dr. Baskin discussed the

possibility of a partial resection of the distal end of the clavicle. However, claimant and Dr. Baskin decided on conservative treatment instead. Dr. Baskin reported that he could not promise that claimant would not need surgery in the future or that he would be totally pain free. He released claimant to full shoulder activity in November 1983. (Ex. A.) Over the years, claimant experienced nondisabling symptoms in his shoulder such as occasional grabbing and clicking, as well as minor stiffness and discomfort. (Exs. 8A, 10 and 16B.)

On June 5, 1989, claimant sustained an injury on the job at Columbia Two, Inc., when he lifted a heavy briefcase. Claimant complained of pain in the right medial scapula and flank. A medical examination found tenderness in the right rhomboid region. The diagnosis was rhomboid strain. (Ex. 1.) Claimant drew the area of discomfort on a body chart. The only area indicated was that over his rhomboid muscle at the lower right scapula toward the thoracic spine. Claimant also stated on this form that he had received no prior treatment for this problem. (Ex. 2.) The right AC joint was not involved in this injury.

The injury in this claim occurred on April 25, 1990 while claimant was lifting a heavy propane tank. On his claim form filled out that date, claimant wrote that he had a "torn back muscle" in his right upper back. He also wrote that he had injured this body part before in 1989 at Columbia Two, Inc. There was no mention of the right AC joint or the 1983 injury. (Ex. 4.) On that same date, claimant sought treatment from R. Craig Dougan, M.D., industrial physician. Dr. Dougan reported that claimant reported pain in his right upper back and quoted claimant as saying that this injury was "absolutely similar" to his 1989 injury at Columbia Two, Inc. Dr. Dougan examined claimant's right shoulder and noted that there was a right AC lump from a previous injury. Dr. Dougan reported no pain or other symptoms in the shoulder upon palpation or range of motion tests. Of special note, Dr. Dougan reported, "Five or six years ago he had a separated right acromioclavicular joint. It is not bothering him at this time." Dr. Dougan diagnosed recurrent and acute right dorsal thoracic strain of the rhomboids. He prescribed four weeks of physical therapy. (Ex. 5.)

In follow up visits with Dr. Dougan on April 30, 1990 and May 8, 1990, claimant reported no problems with his right AC joint. (Exs. 6, 7.) There are no reports from the physical therapist indicating complaints in the AC joint.

Dr. Dougan referred claimant to T. Martens, M.D., orthopedic consultant, where he was seen on May 22, 1990. In a report of that date, Dr. Martens noted in the history that claimant "felt a recurrence of the pulling pain in his right acromioclavicular joint" when he was injured on April 25, 1990. As a result, Dr. Martens diagnosed a strain of the right AC joint due to the April 25, 1990 injury. (Exs. 8, 8A.) This is the first time that the medical records report a history from claimant of injury to his right AC joint.

On June 6, 1990, claimant sought treatment with Michael Graham, M.D., orthopedic surgeon. In a chart note of that date, Dr. Graham reported the history that, at the time of the April 25, 1990 injury:

> "[Claimant] felt something pull in the shoulder and developed pain promptly in the area of the right acromioclavicular joint. Subsequently he has continued to have pain with use in the shoulder, particularly with overhead use or with abduction of the arm across the shoulder. He has also noted a grinding sensation in the shoulder with circumduction." (Ex. 10.)

Based on this history, Dr. Graham diagnosed a AC joint strain superimposed on a preexisting old AC joint instability related to the April 25, 1990 injury.

On June 7, 1990, claimant reported to Ellen Fineman, P.T., that at the time of the April 25, 1990 injury, he "felt a sharp pain in his right shoulder." (Ex. 12.)

In his July 12, 1990 chart note, Dr. Graham reported that claimant's AC joint pain had "been going on since April." (Ex. 13.) He recommended resection of the distal clavicle.

In an independent examination by Douglas Bald, M.D., orthopedic surgeon, on August 1, 1990, claimant reported that he sustained a sharp pain in his right shoulder area on April 25, 1990. Claimant also denied any permanent residuals from his 1983 shoulder injury. Based upon a review of the medical records and careful discussion of the injuries with claimant, Dr. Bald concluded that the 1983 injury and a normal progression of the resultant degenerative arthritis and joint disruption was the major cause of claimant's AC joint condition and related need for surgery. (Ex.15.)

Dr. Graham disagreed with Dr. Bald on the basis of claimant's history of an AC joint strain on April 25, 1990 with continued painful, grinding symptoms since that time, as compared to relatively pain free symptoms from 1983. (Ex. 16B.)

Surgery revealed that the right AC joint was degenerative. No acute, recent trauma was noted. (Ex. 17.)

After a review of the records, Wayne Norton, M.D., medical advisor for SAIF, noted the discrepancy in claimant's reporting of the onset of symptoms to the different doctors. He also noted there was no reasonable likelihood of a masking effect or confusion in the diagnosis, because the anatomic locations of the AC joint and the rhomboid muscles are sufficiently remote from one another. (Ex. 18.)

Upon further inquiry, Dr. Dougan doubted that the AC joint condition was an industrial injury. (Ex. 19A.)

Upon again being supplied with the history that claimant injured his shoulder on April 25, 1990, Dr. Graham reiterated that claimant's AC joint condition and need for treatment was caused in major part by that injury. (Ex. 20.)

The medical reports above show inconsistency in claimant's report of a shoulder injury on April 25, 1990 ranging from no report of symptoms contemporaneous with that date, to reports of a slight pull to reports of a sharp pain.

At hearing, claimant's testimony varied with the history in the reports of Dr. Dougan, Dr. Graham, Ms. Fineman and Dr. Bald. Claimant said he did feel a slight pull in his shoulder on April 25, 1990 and that he told this to Dr. Dougan. (Tr. 15, 44.) He also testified that he told Dr. Dougan that he had pain in his shoulder, but then later testified that he couldn't remember if he told him that. (Tr. 16, 41.) He also testified that he "might" have had pain in his shoulder when Dr. Dougan examined him. (Tr. 17.) As noted above, Dr. Dougan's report specifically notes an absence of shoulder symptoms in his exam.

Claimant testified that he did not tell Dr. Graham that he had immediate pain in his shoulder, but that he only had a pull at the time of injury with the pain coming on later in physical therapy. (Tr. 24, 25, 44.) As noted above, Dr. Graham relied on a history that claimant experienced immediate pain and grinding in his shoulder that was continuous thereafter.

Claimant testified that he did not remember telling Ms. Fineman of immediate, sharp pain in his shoulder. (Tr. 33, 34.) Ms. Fineman's report is to the contrary.

Finally, claimant first testified that he could not remember if he told Dr. Bald of immediate, sharp shoulder pain, then he said he thought he had told him that. (Tr. 25, 34.) He further indicated that he had told him that he had only felt a pull in his shoulder initially, and that the pain came on later in physical therapy as he had earlier testified. (Tr. 25.) Dr. Bald's report is to the contrary as noted above.

At hearing, claimant's theory to explain the inconsistencies was that the medical providers omitted or misconstrued his history of his shoulder injury and that claimant was unsure in describing the anatomical areas of his symptoms. This explanation is unpersuasive given claimant's past ability to specifically describe his areas of symptoms when he suffered specific injuries to his right AC joint in 1983 and to his right rhomboids in 1989.

We give greater weight to the conclusions of a treating physician unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, we are persuaded to do otherwise. We find claimant's history regarding the onset and course of his right shoulder symptoms to be unreliable. Dr. Graham accepted and relied on an inaccurate history, which stated that the initial diagnosis of claimant's condition was a rhomboid strain and AC joint strain. (Exs. 8A and 10.) In addition, claimant was reported to be symptomsfree of from 1983 to 1990. However, claimant experienced intermittent difficulties during that period, although they were nondisabling. (Ex. 16B.) We are unable to rely upon Dr. Graham's opinion to find this claim compensable since it is based on this unreliable history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Accordingly, we find that claimant has failed to prove by a preponderance of the evidence that his right AC condition and need for treatment is related to the injury of April 25, 1990.

ORDER

The Referee's order dated January 28, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

Board Member Gunn dissenting.

My respected colleagues start out by making a medical diagnosis of a patient they have never seen. Medical diagnoses should be left to physicians.

The Referee offers a well-reasoned Opinion and Order arising from substantial evidence in the record. Just as I have concerns with practicing medicine without a license, I see no reason to substitute the majority's legal conclusions for those of the Referee. I would affirm and adopt the Referee's Opinion and Order.

Therefore, I dissent.

In the Matter of the Compensation of
GABE W. PAULK, Claimant
WCB Case No. 90-22077
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Peterson's order which set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

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

In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). A worsened condition is established with evidence of increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Leroy Frank, 43 Van Natta 1950 (1991). In addition, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1), (3). Finally, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

The insurer first contends that claimant failed to establish his claim by medical evidence supported by objective findings. Although the insurer concedes that the reports of Dr. Kemple, rheumatologist, claimant's treating physician, "likely" satisfy ORS 656.273(1) as construed by our order in Suzanne Robertson, 43 Van Natta 1505 (1991), the insurer "contends [that] the Board's interpretation of 'objective findings' in Suzanne Robertson is too broad."

We note the insurer's objection to Suzanne Robertson and conclude that, as construed by that order, claimant satisfied ORS 656.273(1). Dr. Kemple found spasms in claimant's "lumbosacral paraspinals", (Ex. 35A), "prominent muscle tightness and spasm with motion" and "tenderness diffusely through the bilateral paraspinal muscles," (Ex. 38B-1).

The insurer next argues that we should give more weight to the reports from the Orthopaedic Consultants rather than the opinion of Dr. Kemple. The insurer asserts that Kemple did not adequately explain the basis for his diagnosis, assuming that claimant's aggravation was due to his original injury rather than basing that opinion on "objective medical testing."

The record clearly demonstrates a divergence of opinion regarding the cause of claimant's symptoms between the Orthopaedic Consultants and Dr. Kemple. The Orthopaedic Consultants saw claimant three times: in April 1988, May 1990, and October 1990. The Consultants found that claimant's "subjective complaints remain[** ed] disproportional to objective finding[s]," and that "a very clear cut functional point is present * * *, manifested by the pain behavior, the positive Waddell's, the diffuse tenderness to very light touch." (Ex. 39-5).

Dr. Kemple, on the other hand, diagnosed claimant as suffering from "chronic post traumatic myofascial syndrome," stating that the major pain elements "are no doubt a reflection of prolonged and pathologic response to the original injury." (Ex. 43-1). Kemple admitted that there was "not a medical consensus" regarding the term "myofascial syndrome" and that some physicians

interpreted it as functional pain. (Ex. 44-5). He "assumed," however, that the diagnosis was caused by a "pathologic or an abnormal response to injury that produces a chronic disturbance in pain regulation." (Id).

When the medical evidence is divided, we give greater weight to the conclusion of the claimant's treating physician, absent persuasive reasons not to do so. See e.g. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we do not find persuasive reasons not to give Dr. Kemple's opinion greater weight. Although the Orthopaedic Consultants saw claimant three times over a two-year period, Kemple has been treating claimant since 1988. His reports demonstrate that he is familiar with claimant's history and physical condition. We further find, contrary to the insurer's suggestion, that the difference in medical opinion regarding a medical term between Kemple and the Orthopaedic Consultants is not sufficient by itself for us to disregard Kemple's opinion. Therefore, based on Kemple's opinion, we conclude that claimant proved a compensable claim for aggravation.

Furthermore, because the insurer requested review and the Board did not disallow or reduce the compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under 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 is $800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 14, 1991 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $800, payable by the insurer.

In the Matter of the Compensation of
ROBERT L. ROWIN, Claimant
WCB Case No. 90-14453
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Schultz' order which upheld the insurer's denial of claimant's injury claim for a myocardial infarction. On review, the issue is compensability.

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

We agree with the Referee that claimant failed to prove that his work activities on May 22, 1990 were a material contributing cause of his myocardial infarction. The record contains opinions from four physicians regarding medical causation. All of the doctors agreed that claimant's myocardial infarction was caused by a blood clot, or thrombosis, that obstructed the artery. As described by claimant's treating physician, Dr. Brodeur, cardiologist, the clot "occurs when the thin fibrous covering of the arteriosclerotic plaque becomes disrupted and releases elements into the blood supply which activates platelets to

coalesce at the site[.]" (Ex. 38-2). Brodeur reported that, although claimant's arteriosclerotic plaque had developed for many years prior to the myocardial infarction, the disruption of the plaque in claimant's case was caused by the physical exertion necessary to carry out his work activities. (Id.) Specifically, Brodeur reported that when claimant "was carrying the lumber up [to] the roof [of the construction site,] he experienced sufficient imbalance of the blood supply to this area of the coronary artery to cause severe ischemia." (Id. at 2-3).

The remaining physicians saw claimant for independent medical examinations. One of those physicians, Dr. Toren, cardiologist, reported that the plaque rupture experienced by claimant "occurs as part of the natural progression of underlying coronary artery disease" and "appears to occur randomly in the course of patients with this chronic disease." (Ex. 42-1). He therefore found that it was "medically probable that [claimant] would have been as likely to have sustained his [myocardial infarction] had he been at rest or asleep at the time of his symptom onset[.]" (Id. at 2).

Dr. DeMots, cardiologist, agreed with Toren, finding that there was no evidence that physical exertion could lead to plaque disruption, and that such a belief "remains only speculation." (Ex. 45-2). DeMots further stated that it was "medically probable that there is no relationship between the work activities" and the myocardial infarction. (Id.)

Dr. Kremkau, cardiologist, first noted that the "exact factors which lead to plaque rupture and blood clot formation are not well understood." (Ex. 43-4). Further, it was "unclear" to her whether chemical or physical trauma could lead to plaque disruption. (Id.) Thus, Kremkau could only state that, because claimant "had been working 3 or 4 hours doing moderately heavy work," she found it "possible that this work activity was a material contributing cause to the myocardial infarction[.]" (Id.)

Because this case involves expert medical analysis rather than expert observation, we give no particular deference to the opinion of Dr. Brodeur, claimant's treating physician. Hammons v. Perini Corp., 43 Or App 299 (1979). Like the Referee, we also are convinced that, Dr. Brodeur's opinion is overcome by the reports of Drs. Toren, DeMots, and Kremkau. First, Dr. Brodeur himself states that "[e]xactly what [is] the cause of the disruption of this thin fibrous plaque [], is subject to considerable debate." (Ex. 38-2). Dr. Kremkau agreed with this statement, adding that she was unsure whether severe ischemia could cause plaque disruption. (Ex. 43-4). Dr. Toren knew of "no association between the development of plaque rupture with coronary thrombosis formation and physical exertion or emotional stress." (Ex. 41-1). Dr. DeMots also could find no evidence supporting a causative relationship between physical activity and plaque disruption. (Ex. 45-2). We are reluctant to find Dr. Brodeur's opinion more persuasive than the other reports in view of the lack of agreement in the record before us regarding the causal link, if any, between physical exertion and myocardial infarction.

Second, Dr. Brodeur based his opinion on an inaccurate history of claimant's activities on the day that he suffered a myocardial infarction. Brodeur stated that claimant "was carrying twelve to eighteen feet long pieces of lumber up the roof of the convention center" when he "started to feel extremely tired and exhausted and started sweating profusely." (Ex. 38-1). Brodeur further found that claimant experienced "severe ischemia" when he was carrying the lumber up to the roof. (Id. at 2-3).

According to claimant's testimony at hearing and the other medical reports, however, claimant never carried lumber up to the roof. Instead, he first

worked on the roof stacking boards, then went down to the ground to unload boards from a truck. Because Brodeur was incorrect that claimant carried boards to the roof, and this event was, for him, the triggering incident in claimant's myocardial infarction, we are further persuaded that Brodeur's report should not be accorded as much weight as the other opinions.

ORDER

The Referee's order dated April 23, 1991 is affirmed.

February 20, 1992 Cite as 44 Van Natta 308 (1992)

In the Matter of the Compensation of
PATRICIA C. VOGT, Claimant
WCB Case No. 87-18519
ORDER DENYING RECONSIDERATION
Malagon, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Claimant has requested reconsideration of our May 24, 1990 Order on Review that affirmed a Referee's order which upheld the self-insured employer's denial of claimant's injury claim. Claimant acknowledges that this matter is currently pending before the Court of Appeals pursuant to her appeal of our order. However, enclosing a report from a "forensic document examiner" which "provides significant support for [her] contention that the testimony of [the principal at the school where she was employed] is unacceptable, inaccurate, and potentially infected by intentional deceit," claimant seeks reconsideration of our order under ORS 183.482(6) and reopening of the record. The employer has filed a response to claimant's request. Having considered the parties' arguments, we proceed to address claimant's request.

At any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). However, this authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

In our previous order, we affirmed a Referee's order which upheld the employer's denial of claimant's injury claim. In doing so, we concluded that claimant had failed to establish that her disability and need for medical treatment was caused by a falling or tripping incident at a school in July 1987. In reaching this conclusion, we agreed with the Referee's reasoning that claimant was neither a credible witness nor historian.

Claimant seeks reconsideration of our order and reopening of the record for the introduction of a report from "a forensic examiner." She alleges that this report "provides significant support for [her] contention that the testimony of [the principal at the school where she was employed] is unacceptable, inaccurate, and potentially infected by intentional deceit." Reasoning that this evidence has a significant impact on the credibility of the principal and that her only course of action for such "false, fraudulent or perjurious" conduct rests with the workers' compensation system, claimant asks that we reconsider our order and remand this matter to the Referee for the taking of additional evidence pursuant to ORS 656.295(5).

We deny the requests for reconsideration and remand. To begin, claimant acknowledges that oral argument was scheduled for February 13, 1992. Furthermore, we have been notified by the court that the argument was held as

scheduled. Inasmuch as the "date set for hearing" on claimant's appeal has past, we are without authority to reconsider our order. See ORS 183.482(6).

Assuming arguendo that we retained authority to reconsider our order, we would decline the opportunity. We may remand to the Referee for the taking of additional evidence should we determine that a case has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To justify remand, it must be shown that the evidence to be admitted was unobtainable with the exercise of due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641, 647-48 (1986); Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, claimant has not established that the evidence which she seeks to introduce was unobtainable with the exercise of due diligence at the time of hearing. To the contrary, she acknowledges that since her claim involved a disputed fall, the issues of credibility for herself and the principal "are, and have been, central in the resolution of the factual dispute." Considering claimant's admitted recognition of the importance of witness credibility to this case, we are not persuaded that the proferred evidence (which pertains to the "forensic examiner's" report regarding an examination of claimant's "801" form and documents bearing the signature of the principal) was unobtainable at the time of hearing with the exercise of due diligence.

Accordingly, claimant's motion for reconsideration and remand is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

In the Matter of the Compensation of
GILBERT G. ARCHER, JR., Claimant
WCB Case Nos. 86-16025 & 86-10377
ORDER ON REMAND
Gastineau & Smith, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Arthur Stevens (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Southwest Forest Industries v. Archer, 109 Or App 349 (1991). The court reversed our prior order, which found Southwest Forest Industries, as a self-insured employer, responsible for claimant's back condition. In setting aside Southwest's denial of claimant's aggravation claim, we determined that an April 1985 disputed claim settlement (DCS) did not preclude claimant from establishing an aggravation claim for his current back problems. The court reasoned that if the physical problems claimant was suffering at the time of his April 1986 aggravation claim were the same as those he had at the time of the DCS, the settlement would establish that claimant's problems were unrelated to his employment with Southwest. The court further noted that, if claimant's 1986 problems were different, then we must decide whether the DCS barred claimant from asserting an aggravation. Inasmuch as our prior order made no findings concerning whether claimant's physical problems when he filed his aggravation claim "were medically any different" from those he had when the DCS issued, the court remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our first order except for the second full sentence on page 2 and instead provide the following.

In April 1985, claimant and the self-insured employer, Southwest Forest Industries, entered into a disputed claim settlement (DCS). The Referee approved the settlement. The DCS stated that Southwest had "denied the compensability of the present problems [to claimant's upper, mid and low back] and psychiatric origin of them." It further provided that Southwest:

> "contends that Claimant's problems with his upper, mid and low back have no physical etiology but are due to psychiatric and psychological problems. That these problems are unrelated to and did not arise out of or during the course of Claimant's employment with the Employer or were they caused, aggravated, worsened, or contributed to by the industrial injury. That the psychiatric problem is pre-existing and unrelated to the industrial injury. * * *"

Finally, the DCS stated that "the Employer's denial and Employer's contentions contained in this stipulation shall be affirmed."

FINDINGS OF ULTIMATE FACT

Claimant's condition as of April 1986, when he filed a claim for aggravation, was not different from his condition as of the April 1985 DCS.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had suffered neither an aggravation of his 1984 compensable back injury with Southwest nor a "new injury" while at SAIF's insured. We reversed that portion of the Referee's order which upheld the self-insured employer's denial of the aggravation claim. We concluded that, although claimant did not prove that he sustained a "new injury", he did demonstrate that he had an ongoing back condition, attributable to the 1984 injury, which was symptomatically aggravated by the work at SAIF's insured. We based our conclusion on our finding that the DCS "affirmed the employer's acceptance of claimant's back injury and upheld the employer's denial of claimant's psychiatric claim."

The Court of Appeals disagreed with our finding concerning the DCS, stating that the "Board erred as a matter of law when it did not correctly read and apply the settlement order." Southwest Forest Industries v. Archer, supra, 109 Or App at 353. The court found that the DCS, along with affirming the acceptance of claimant's back injury and upholding the denial of the psychiatric claim, also "affirmed" the employer's contentions that claimant's upper, middle and low back problems were unrelated to his employment, had no physical origin and were due to psychiatric and psychological problems. The court remanded to the Board for findings "about whether claimant's physical problems when he filed the aggravation claim in April, 1986, were medically any different from those he had in March, 1985, when the settlement order issued." Id. The court further instructed that, if the Board "finds that the 1986 problems were different, then it must decide, under a correct reading, whether the settlement order bars [claimant] from asserting an aggravation." Id.

The record contains two opinions regarding claimant's condition while working at SAIF's insured. Dr. Peterson, orthopedist, first treated claimant on March 31, 1986, for claimant's complaints of increased back pain, which claimant related to his work at SAIF's insured. (Ex. 57). On July 8, 1986, Peterson

stated that claimant's "condition has been an ongoing problem," and that claimant had sustained a back strain at SAIF's insured, "with symptoms also being contributed by his previous condition." (Ex. 68). On August 8, 1986, Peterson found, "from reviewing the history given by [claimant], that he had an ongoing back condition which was symptomatically aggravated by his employment at" SAIF's insured. (Ex. 72). Peterson reiterated this opinion at hearing, stating that it was his opinion that claimant "did not have a significant new injury * * * but a symptomatic increase in back pain." (Tr. 21).

On November 12, 1986, claimant began treating with Dr. McIlvaine, D.C. Dr. McIlvaine found that claimant had suffered three separate injuries to his low back and that each injury had contributed "percentagewise [sic] to his present condition." (Ex. 79). On March 12, 1987, McIlvaine stated that the work at SAIF's insured "did contribute to a change and worsening of [claimant's] condition." (Ex. 91). At hearing, McIlvaine explained that an injury to tissue that is superimposed on an already injured area of the body creates a worsening of the condition. In claimant's case, he found that claimant's work at SAIF's insured had independently contributed to a worsening of claimant's back condition. (Tr. 87).

The medical evidence thus is divided whether claimant's condition changed between the issuance of the DCS and the filing of his aggravation claim. As we did in our first order, we defer to the opinion of Dr. Peterson. As an orthopedist, Peterson has special training and expertise in diagnosing claimant's condition, as opposed to Dr. McIlvaine, who is a chiropractor. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Peterson also initially saw claimant shortly after claimant began complaining of increased back pain and before claimant filed his claim for aggravation; McIlvaine did not see claimant until seven months after claimant filed his claim. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986).

Based on Dr. Peterson's opinion, we conclude that claimant's back condition was ongoing and that his physical problems were no different at the time of his April 1986 aggravation claim than they were at the time of the DCS. Because his condition did not change, and the DCS established that claimant's condition was unrelated to his employment with Southwest, claimant is precluded from asserting his claim for aggravation. In light of our conclusion that claimant's aggravation claim is not compensable, it is unnecessary to address claimant's attorney's entitlement to an attorney fee award.

Accordingly, on reconsideration, the Referee's order dated August 4, 1987 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
WCB Case Nos. 90-20969 & 90-07762
MARY L. SWANGER, Claimant
ORDER ON REVIEW
Depaolis, et al., Claimant Attorneys
Sandra K. Haynes, Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant requests review of that portion of Referee Livesley's order that upheld the insurer's partial denial of claimant's bilateral thoracic outlet syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of facts.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that the Referee erred in failing to find the insurer responsible for claimant's thoracic outlet syndrome. Relying on SAIF v. Abbott, 103 Or App 49 (1990), she contends that the insurer has accepted the condition by virtue of having accepted symptoms of the disease. We disagree.

Claimant's reliance on Abbott is misplaced. At the outset, we note that the court has subsequently withdrawn and reconsidered its decision in Abbott and remanded for reconsideration. 107 Or App 53 (1991). Moreover, to the extent that Abbott remains valid law, we find it distinguishable from the case before us. In Abbott, a worker sustained an on-the-job injury initially diagnosed as a wrist and arm sprain. On the claim form, he described the injury as involving swelling, aching and hand numbness. After the claim had been accepted, the worker's condition was diagnosed as carpal tunnel syndrome. Relying on Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the court first noted that an acceptance of the compensability of specific symptoms includes the acceptance of the compensability of the disease causing those symptoms. Because the carrier had accepted the worker's condition involving swelling, aching and hand numbness, the court concluded that the acceptance encompassed the disease causing those symptoms, which turned out to be carpal tunnel syndrome. 103 Or App at 54.

In this case, however, the insurer did not accept the compensability of symptoms that later proved to be thoracic outlet syndrome. To the contrary, it accepted a temporary exacerbation of claimant's cervical arthritis. That acceptance does not include the thoracic outlet syndrome, because those are two separate infirmities. See Georgia-Pacific v. Piwowar, supra at 501. Moreover, contrary to claimant's assertion, there is no persuasive medical evidence that both conditions are simply two different diagnoses for the same set of symptoms. Dr. Gallo, claimant's treating physician, has consistently treated the conditions as two separate entities since originally diagnosing thoracic outlet syndrome. While Dr. Gallo believes that the cervical exacerbation was causally related to the 1986 compensable injury, she is yet unable to determine the cause of the thoracic outlet syndrome. (Ex. 36). Medical reports from Dr. Throop and Dr. Englander also evidence a distinction between conditions. Accordingly, we conclude that the insurer did not unwittingly accept the condition of thoracic outlet syndrome by its acceptance of the exacerbation of claimant's cervical arthritis. See John L. Katzenbach, 41 Van Natta 1465 (1989), aff'd on other grounds 104 Or App 732 (1990).

ORDER

The Referee's order dated March 13, 1991 is affirmed.

In the Matter of the Compensation of
RONALD E. INGRAM, Claimant
WCB Case Nos. 90-12242 & 90-15187
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Brian Pocock, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Livesley's order that affirmed: (1) a Determination Order award of 6 percent (19.2 degrees) unscheduled permanent disability for a cervical spine injury; and (2) a Determination Order award of 1 percent (3.2 degrees) unscheduled permanent disability for a cervical spine condition. On review, the issues are extent of scheduled and unscheduled disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We note, preliminarily, that under the applicable law, we rate disability as of the date of hearing, not as of the date of claim closure. The amendments to ORS 656.283(7) and 656.295(5), which create a different rating principle, do not apply because claimant became medically stationary before July 1, 1990. See Or Laws 1990, Ch. 2, Sec. 54(3). Stephen A. Roberts, 43 Van Natta 1815 (1991).

The Referee affirmed the January 9, 1990 Determination Order and the June 27, 1990 Determination Order which awarded claimant a combined total of 7 percent unscheduled permanent disability. We apply the "standards" in effect on the dates of these Determination Orders. WCD Admin. Order 1-1989.

The Referee found that claimant had not established that his impairment, if any, was caused by the compensable cervical injury or the compensable occupational disease involving his hands, wrists, arms, shoulders, neck, and upper body. We agree that claimant has not established a causal relationship between his cervical impairment and his compensable conditions. However, we find that the necessary causal relationship was established for claimant's shoulders, forearms (wrists), and arms (elbows).

Dr. Schachner, orthopedist, examined claimant twice, once on November 4, 1988, prior to the current claims, and again on May 18, 1989, after the current claims were made. (Exs. 1, 2). Dr. Schachner opined that claimant's cervical complaints were due to the degenerative disc disease and nerve root irritation at the cervical level. (Exs. 1-3, 2-4).

Dr. Scofield, treating chiropractor, provided the only other evidence relating to the cause of claimant's cervical impairment. (Ex. 2E). Dr. Scofield did not address any degenerative aspect of claimant's impairment and merely stated that claimant's cervical misalignment was "traumatically induced." (Ex. 2E-1).

Given Dr. Scofield's incomplete report, and Dr. Schachner's expertise as an orthopedist, we find Schachner's opinion more persuasive. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Thus, we find any cervical impairment to be due to claimant's degenerative disc disease.

However, contrary to the employer's contentions, the medical evidence does not establish that impairment in claimant's shoulders, elbows, and wrists was

preexisting and not due to the compensable occupational disease. Although Dr. Schachner noted in his November 4, 1988 report that claimant's left wrist x-rays showed very early degenerative changes, he also noted that claimant's wrist flexion was intact bilaterally and that he had no restrictions in either radial or ulnar deviation in either wrist. (Ex. 1-3). Furthermore, no medical evidence relates any wrist impairment to these early degenerative changes. In addition, during the November 1988 examination, the findings Dr. Schachner made relating to claimant's shoulders and elbows were normal. (Ex. 1-3). Thus, we find that any impairment in claimant's shoulders, elbows, and wrists is due to the compensable occupational disease.

Claimant's permanent impairment can be rated only after he becomes medically stationary. Dr. Scofield provides the only range of motion measurements after claimant became medically stationary. However, we agree with the Referee that Dr. Scofield's measurements do not comply with former OAR 436-36-005(1) and are incapable of being interpreted as compatible with the "standards." We do not find Dr. Scofield's range of motion measurements persuasive because he used measurements which include different values for "normal" findings than those used in the "standards." See former OAR 436-35-005(1); Lawrence E. Wilson, 43 Van Natta 1131 (1991); Richard C. Kelly, 42 Van Natta 2408 (1990). Furthermore, his measurements regarding loss of grip strength are not convertible to a rating under the standards. Thus, we find that claimant has not established impairment under the "standards." If no measurable impairment is established, no award of either scheduled or unscheduled permanent disability is allowed. Former OAR 436-35-010(1)(b); 436-35-270(2).

The employer does not seek reduction of the Determination Orders which the Referee affirmed; therefore, we affirm the Referee's order.

ORDER

The Referee's order dated March 8, 1991 is affirmed.

In the Matter of the Compensation of
WILLIAM E. EASLEY, Claimant
WCB Case No. 90-19698
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Charles J. Cheek (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the SAIF Corporation's "de facto" denial of his injury claim for his low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the exception of the first full paragraph on page 3.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established that the industrial accident of February 23, 1989 was a material contributing cause of claimant's low back condition, which required medical services or resulted in disability.

However, the Referee concluded that medical evidence supported by objective findings did not exist, and therefore, claimant's injury claim was not compensable.

At the outset, we find that claimant's injury claim is properly characterized as a primary consequence of an industrial accident. See Julie K. Gasperino, 43 Van Natta 1151 (1991). The Referee accepted, and the medical evidence supports, claimant's report that, while he was changing rigging on the job, a log struck him in the low back area, the hip area and across the legs. Although claimant's most apparent injury at the time of the accident was a fractured right femur, claimant now seeks compensation for a condition he alleges arose from the February 1989 incident. Therefore, in order to establish compensability, claimant must show that the February 23, 1989 accident was a material contributing cause of his low back condition and need for medical services. Mark Wiedle, 43 Van Natta 855 (1991).

Claimant had no low back problems prior to the industrial injury. However, in April 1989, he reported to Dr. Adams, his treating physician, that he had had a backache ever since he was hit by the log. Dr. Adams recommended that claimant continue to swim and exercise as it was the best thing for his back.

In July 1989, claimant began physical therapy with the goals of decreasing his low back pain and increasing his strength in the right lower extremity. Claimant's physical therapist noted on July 24, 1989 that claimant continued to have a chief complaint of low back pain. The therapist reported that claimant was "seen for cold to the low back to reduce swelling inflammation."

On October 13, 1989, Dr. Adams reported that claimant had complained about his back ever since his injury, although no structural abnormality had been found. Dr. Adams concluded that the "etiology of his back is from the mechanism of injury he sustained." Dr. Adams also reported that he assumed claimant's back injury occurred when he was struck by the log.

In December 1989, Dr. Adams reexamined claimant's back and reported that claimant was "tender to light touch in the back." Dr. Adams reported, however, that he was unable to find objective evidence on exam, "other than just tenderness."

In May 1990, Dr. Adams reported that claimant's back bothered him periodically and claimant complained of pain with extension of his back and full forward flexion.

In a February 1991 deposition, Dr. Adams testified that the industrial accident in which claimant was struck by a log was the major contributing cause of his particular back problem. Dr. Adams assumed that when claimant was struck by the log, he contused and strained his back. Dr. Adams stated that, other than local tenderness, claimant did not have any neurological signs of a back injury. Dr. Adams further testified that, although he did not see anything externally obvious, when a person was hit in the back with a log it was "bound to do something back there." Dr. Adams also stated that, although he was dealing with subjective back pain, "we have to assume that -- at least I assume that when we got -- he said his back pain came on after he got hit with the log so I have no reason to doubt him."

Subsequent to the Referee's Opinion and Order, we interpreted objective findings, as defined by ORS 656.005(19), to include a physician's finding of a condition such as tenderness. See Suzanne Robertson, 43 Van Natta 1505 (1991); Herb R. Davidson, 43 Van Natta 1820 (1991). Furthermore, we concluded that legislative history existed that expressed an intent to base objective findings

upon not only physically verifiable impairment, but also upon a physician's evaluation of the worker's description of the pain he is experiencing. Robertson, supra at 1507.

In the present case, claimant did not have a back condition prior to his industrial injury and SAIF does not contend that claimant was not struck in the back by a log. Additionally, Dr. Adams believed claimant's reports of back pain and on several occasions he documented local tenderness in the back area. Claimant also received physical therapy for his back condition and chart notes document that he received cold therapy for "swelling inflammation" of the low back. Finally, Dr. Adams reported that the accident was the major cause of claimant's back condition and he found no reason to doubt claimant's complaints of pain.

Under the circumstances, we conclude that claimant has established a compensable back injury claim and we find that the medical records, including Dr. Adam's reports and deposition, constitute medical evidence supported by objective findings, as required by amended ORS 656.005(7)(a).

Claimant's counsel is entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review for prevailing on the issue of compensability of claimant's injury claim. See 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 $2,500 is a reasonable assessed fee for claimant's counsel's efforts. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue presented and the value of the interest involved.

ORDER

The Referee's order dated April 30, 1991 is reversed. The SAIF Corporation's "de facto" denial is set aside and the low back injury claim is remanded for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded a $2,500 assessed fee, to be paid by SAIF.

In the Matter of the Compensation of
PENELOPE A. BEHEE, Claimant
WCB Case No. 90-19154
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Gruber's order which set aside its denial of claimant's injury claim for a cervical condition. On review, the issue is compensability.

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

Claimant suffers from preexisting degenerative joint disease in her neck. The Referee correctly analyzed this case by applying a two-part test in which he first determined claimant had sustained an injury which was a material contributing cause of her disability or need for treatment. Then the Referee determined that claimant had a preexisting condition which combined with her injury to prolong her disability or need for treatment and which was the major

contributing cause of the resultant disability or need for medical treatment. Bahman M. Nazari, 43 Van Natta 2368 (1991).

We agree with the Referee's conclusion that Dr. Johnson's opinion on causation is more persuasive than that of Dr. Worthington. Dr. Johnson is claimant's treating physician and surgeon. Dr. Johnson is a specialist in orthopedic surgery. Further, he performed claimant's cervical surgery. The employer argues that Dr. Johnson bases his opinion on the temporal relationship between the injury and the onset of cervical problems. We note that causation cannot be inferred from temporal proximity alone. See Allie v. SAIF, 79 Or App 284, 288 (1986); Edwards v. SAIF, 30 Or App 21 (1977), rev den, 279 Or 301 (1977). However, Dr. Johnson also bases his decision on the nature of the trauma claimant suffered during the industrial injury. We find no persuasive reason not to defer to Dr. Johnson. Weiland v. SAIF, 64 Or App 810, 814 (1983). We, therefore, agree with the Referee that Dr. Johnson's opinion is persuasive.

The employer also argues that claimant's noncompensable motor vehicle accident and an incident in which she was struck in the face by a branch while riding a horse are more likely causes of her cervical problems. The Emergency Room records of the motor vehicle accident indicate that claimant sustained only a minor cervical strain. An x-ray of the cervical spine was unremarkable. (Ex. 58).

Similarly, the Emergency Room reports of the incident in which claimant was struck in the face by a branch indicate that claimant's neck was supple and nontender. Furthermore, the admitting diagnosis indicates claimant's primary reason for visiting the hospital was a concern over a possible reaction to medications that claimant was taking. (Ex. 61). There is no indication of an injury to claimant's neck caused by this incident. Claimant was seen by Dr. Smith before her June 12, 1990 injury, but this visit was for problems associated with her low back and not her neck. (Ex. 64). We conclude that there is no persuasive evidence that either noncompensable incident caused claimant's disability and need for treatment.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. 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 attorney's services on review is $1000, to be paid by the self-insured employer . In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 16, 1991 is affirmed. For services on review claimant's attorney is awarded an assessed fee of $1000 payable by the self-insured employer.

February 7, 1992 Cite as 44 Van Natta 317 (1992)

In the Matter of the Compensation of
BECKY L. MALONE, Claimant
Own Motion No. 92-0006M
OWN MOTION ORDER
Aller, et al., Claimant Attorneys

The self-insured employer submitted claimant's claim for an alleged worsening of her April 15, 1982 low back injury. Claimant's aggravation rights

expired on August 2, 1987. The employer has accepted the compensability of a proposed neurolysis and neurectomy surgery and recommends that we authorize the payment of temporary disability compensation.

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

Dr. Freeman, neurosurgeon, opines that a neurolysis and neurectomy at T7-8 on the left is in claimant's best interest. He states that he will initiate authorization for that surgery should claimant so wish." (Letter of August 20, 1991.) However, there is no evidence that claimant has agreed to the surgery, nor is there any indication that Dr. Freeman has requested authorization to perform the surgery. Thus, the evidence fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. Consequently, because claimant's 1982 low back injury has not worsened requiring hospitalization or surgery, we are unable to authorize the reopening of claimant's claim for own motion relief.

In addition, we lack evidence that claimant's current thoracic condition and recommended surgery at T7-8 on the left is causally related to claimant's low back injury. Claimant had low back and left-leg symptoms from the time of injury through 1985. A number of tests and consultations during this period revealed an objectively normal low back. In 1985, Dr. Freeman performed a discectomy at T7-8 and a T7-8, T8-9 laminectomy, which he related to claimant's then recent upper back pain. (Letter of March 27, 1985.) Dr. Freeman opined that the thoracic discectomy "may not cure claimant's low back and left leg symptoms." (Report of April 3, 1985.) In September, 1985, claimant still had pain down her left leg, but by December, 1985, her back and leg complaints had apparently resolved. (Letter of September 18, 1985 and chart note of December 23, 1985).

In October 1988, claimant changed her treating physician to Dr. Schroeder, chiropractor. In 1990, Dr. Schroeder related claimant's low back and left leg complaints to her original low back injury. (Letter of March 8, 1990.) Meanwhile, claimant had experienced a December 16, 1988 injury with a different employer and was also involved in a motor vehicle accident in 1988 or 1989, about which we have little information and either of which may have contributed to her current thoracic condition. We are accordingly unable to attribute claimant's current thoracic condition to her 1982 compensable low back injury.

Thus, even if claimant's condition requires surgery, because her current condition is not a worsening of her original 1982 low back condition, we are not authorized to grant the request to reopen the claim.

Accordingly, we deny claimant's request for own motion relief.

Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEE GOVRO, Claimant
WCB Case No. 90-19870
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Knapp's order that: (1) declined to award an assessed attorney fee for services concerning the insurer's rescission of its denial of claimant's occupational disease claim for his shoulder condition prior to hearing; and (2) awarded claimant's attorney an approved fee out compensation, for his services concerning the insurer's rescission of its denial. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's procedural statement of the case.

CONCLUSIONS OF LAW AND OPINION

On review, claimant argues that his attorney should be awarded an assessed fee in lieu of the approved fee awarded by the Referee. We agree.

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no assessed attorney fee was available for the rescission of a denial prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an assessed attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540 3. Here, the insurer rescinded its denial prior to hearing; the Referee's order denying an assessed attorney fee has not become final.

We adopt the Referee's conclusion that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. Accordingly, an assessed attorney fee for services prior to the hearing is warranted. ORS 656.386(1).

ORS 656.386(2) provides, in relevant part, that in all cases other than those specified in subsection (1) of the statute, attorney fees shall be paid from the claimant's award of compensation. As amended ORS 656.386(1) now provides for an assessed attorney fee for services prior to the hearing, an approved attorney fee for the same services is not warranted. Accordingly, no attorney fee shall be paid to claimant's attorney out of compensation. Instead, claimant's counsel's fee shall be paid by the insurer.

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 prior to the hearing concerning the rescission of the denial issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's attorney's statement of services), the complexity of the issues and the value of the interest involved.

Rather than being payable from claimant's compensation, as granted by the Referee, the $500 attorney fee is payable by the insurer in addition to

In the Matter of the Compensation of
MICHAEL J. EBY, Claimant
WCB Case No. 89-04768
ORDER ON REMAND
Cournoyer & Sussman, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Eby v. R. L. Hollenbeck & Son, 110 Or App 128 (1991). The court reversed our prior order, Michael J. Eby, 42 Van Natta 2604 (1990), which had declined to award benefits for temporary total disability from August 25, 1987 to June 29, 1988. Noting that the SAIF Corporation had conceded that we had erred in declining to award the aforementioned compensation, the court has reversed and remanded for an award of temporary total disability benefits.

In accordance with the court's mandate, claimant is awarded benefits for temporary total disability from August 25, 1987 to June 29, 1988. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $1,500, pursuant to claimant's retainer agreement. This fee shall be paid directly to claimant's attorney by the SAIF Corporation.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATI A. HANKS, Claimant
WCB Case No. 90-16204
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant requests review of Referee Podnar's order that: (1) denied claimant's request for additional temporary total disability; and (2) declined to assess a penalty and related attorney fee for the self-insured employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are entitlement to temporary total disability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the parties' stipulated facts.

CONCLUSIONS OF LAW AND OPINION

The issue on review is whether claimant was entitled to temporary disability benefits during a labor dispute lock out. Claimant acknowledges that she was not entitled to receive any temporary disability benefits prior to the lock out, because she had returned to modified work at a wage equal to her wage at the time of injury. She contends, however, that she was entitled to temporary disability benefits when she was precluded from performing that modified work during the labor dispute. We disagree.

In Safeway Stores v. Owsley, 91 Or App 475 (1988), the court held that a claimant, who was fired after returning to modified work at a wage equal to his wage at injury, was not entitled to payment of temporary total disability benefits. Because the claimant was away from work for reasons unrelated to his

injury, the court reasoned that he had not lost wages because of an inability to work as a result of his compensable condition. See also Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991) (In the absence of a legislative direction to the contrary, temporary total disability benefits are not available if the loss results from reasons other than the compensable injury).

Although Owsley involved a claimant who had been fired and Wilson involved a claimant who would not cross a picket line, we find the same reasoning applicable here. Claimant sustained a compensable right wrist injury but was provided modified work at equal pay. She did not lose time from work as a result of the injury and, therefore, was not entitled to any temporary disability benefits. She was subsequently precluded from performing that modified work for approximately three weeks during a labor dispute. As the Referee points out, however, there is no evidence that, but for the labor dispute, claimant would not have continued to perform her modified work at full wages. In fact, claimant returned to that work upon the cessation of the strike and lock out. Thus, claimant was away from work for reasons unrelated to her injury. As in Owsley and Wilson, she has not lost wages because of an inability to work as a result of her compensable condition. Therefore, she is not entitled to temporary disability benefits.

ORDER

The Referee's order dated April 5, 1991, as reconsidered May 15, 1991, is affirmed.

February 24, 1992 Cite as 44 Van Natta 322 (1992)

In the Matter of the Compensation of
GARRY D. SMITH, Claimant
WCB Case Nos. 90-12913 & 90-10238
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

Qualified Personnel, a self-insured employer, requests review of those portions of Referee Black's order that: (1) set aside its responsibility denial of claimant's low back condition; (2) upheld Safeco Insurance Company's responsibility denial for the same condition; and (3) concluded that claimant's back claim with Qualified Personnel was prematurely closed. In its respondent's brief, Safeco renews its argument that claimant's claim against it is barred for untimeliness. On review, the issues are timeliness, responsibility, premature closure and, alternatively, extent of permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Timeliness

Safeco contends that claimant's low back injury claim against it is barred by his failure to give written notice of the accident within 30 days. We disagree.

ORS 656.265(4) provides that the defense of late claim filing is available to the insurer only when the delay in the claimant's filing has prejudiced the

employer. The insurer bears the burden of proving prejudice. Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). It must offer facts, not merely conclusory statements or speculation, to make its showing. Nat'l Farmers Union Ins. v. Scofield, 57 Or App 23 (1982).

In this case, Safeco contends that it was prejudiced because the delay prevented it from obtaining independent, contemporaneous medical information following claimant's work exposure. Claimant's injury, however, manifested itself immediately after the work exposure and claimant sought and received prompt medical treatment. His treating physician maintained complete medical records, which are contained in the record, and testified at hearing. Safeco does not dispute the accuracy of this contemporaneous medical evidence and, in fact, relies on portions of it to argue that no new injury occurred. Under these circumstances, and considering the record as a whole, we find that Safeco has failed to establish that it was actually prejudiced by the inability to obtain an additional medical report. See Aetna Casualty Co. v. Kupetz, 106 Or App 670 (1991).

Responsibility

The applicable provision is section 49(1) of Oregon Laws 1990 (Special Session), chapter 2, which provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."

In applying that provision to this case, the Referee first found that Qualified Personnel, the last employer against whom claimant had an accepted low back injury, remained responsible for claimant's condition unless evidence was produced which established that claimant sustained a new compensable injury while working for Safeco's insured. The Referee then concluded that, in order to prove a new compensable injury, the subsequent work exposure must be the major contributing cause of the resultant condition pursuant to ORS 656.005(7)(a)(B).

Subsequent to the Referee's order, we issued Rosalie Drews, 44 Van Natta 36 (1992), in which we held that ORS 656.005(7)(a)(B) was not applicable to the determination of responsibility issues under section 49(1). We noted that ORS 656.005(7)(a)(B) does not determine compensability of an initial injury, but rather limits a carrier's liability for continuing disability or need for medical services. See Bahman M. Nazari, 43 Van Natta 2368 (1991). Accordingly, we concluded that a new compensable injury is established by proving that a subsequent work exposure was a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991).

In this case, subsequent to his original injury with Qualified Personnel and while working for Safeco's insured, claimant was lifting a 35 to 50 pound bucket of bolts when he felt a snapping and sudden sharp pain in his back. He sought treatment from Dr. Johnson, his treating chiropractor, who noted inflammation of claimant's back tissues and a reduced range of motion. At hearing, Dr. Johnson testified that, in his opinion, claimant sustained a new injury while working at Safeco's insured. He noted that, as a result of that exposure, claimant suffered an additional disc tearing and disc injury, as well as inflammation and tissue destruction in his back. He also noted that an MRI scan verified low back injury at two additional lumbar disc levels that were previously

asymptomatic. This was further verified by clinical examination objectively verifying claimant's increased subjective complaints.

Based on that testimony, and in the absence of any contrary medical evidence, we conclude that claimant sustained a new compensable injury involving the same condition while working at Safeco's insured, which injury was a material contributing cause of his need for treatment. See ORS 656.005(7)(a); Or Laws 1990 (Special Session), ch. 2, 49(1). Accordingly, responsibility for all further compensable medical services and disability involving the same condition shall be the responsibility of Safeco.

Premature Closure

We adopt the conclusions and reasoning set forth in the Referee's order with the following supplementation. Because claimant's condition for which Qualified Personnel is responsible was not medically stationary prior to his new injury with Safeco's insured, the November 29, 1990 Determination Order is set aside as premature and the claim is remanded to Qualified Personnel for proper closure. See Wilbur E. Gunderson, 42 Van Natta 263 (1990). We note that, in light of our decision, Qualified Personnel's responsibility for temporary total disability ended on October 12, 1989, the day prior to claimant's new injury. Nonetheless, claimant would be entitled to permanent partial disability, if any, resulting from the Qualified Personnel injury for which the claim was previously open. See Larry K. Rose, 41 Van Natta 69, 72 (1989).

Attorney Fee on Board Review

Because Qualified Personnel initiated the request for review on the premature closure issue and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed attorney fee under 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 attorney's services on review concerning this issue is $100, to be paid by Qualified Personnel. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Claimant's counsel is similarly entitled to an assessed fee under ORS 656.382(2) for services on review concerning the timeliness issue raised in Safeco's brief. Based on similar considerations expressed above, we find that a reasonable fee for such services regarding that issue is $100, to be paid by Safeco.

ORDER

The Referee's order dated January 28, 1991, as amended February 20, 1991, is affirmed in part and reversed in part. Qualified Personnel's responsibility denial of claimant's low back condition is reinstated and upheld. Safeco Insurance Company's responsibility denial for the same condition is set aside and the new injury claim is remanded to Safeco for processing pursuant to law. The attorney fee awarded to claimant's counsel by the Referee in the amount of $2,400 shall be paid to claimant's counsel by Safeco. The remainder of the order is affirmed. For services on Board review regarding the premature closure issue, claimant's counsel is awarded an assessed fee of $100, to be paid by Qualified Personnel. For services on Board review regarding the timeliness issue, claimant's counsel is awarded an assessed fee of $100, to be paid by Safeco.

In the Matter of the Compensation of
LINDA A. CROWE, Claimant
WCB Case No. 91-02717
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of those portions of Referee Peterson's order that: (1) found that claimant established good cause for her untimely request for hearing; and (2) set aside its denial of claimant's occupational disease claim for her bilateral wrist condition. On review, the issues are good cause and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Good cause

The Referee concluded that the denial was issued on January 4, 1991, and therefore, the last day for filing was March 5, 1991. However, subsequent to the Referee's order, we concluded that, pursuant to amended ORS 656.262(8), notice of a denial is the critical event which starts the 60-day time period running. Thomas E. Edison, 44 Van Natta 211 (1992).

Here, the record shows that claimant received the denial by certified mail on January 5, 1991. Accordingly, the last day for filing was March 6, 1991. The Referee found as fact that claimant had established a mailing date for her hearing request of March 4, 1991. We have adopted that finding. Therefore, claimant has established timely filing. OAR 438-05-046.

Alternatively, we agree with the remainder of the Referee's order on the issue of good cause. Accordingly, we adopt his conclusions and opinion on that issue.

Compensability

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

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. 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 attorney's services on review is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 6, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
DENISE K. RODRIGUEZ, Claimant
WCB Case No. 91-01126
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee McWilliams' order which declined to award an assessed attorney fee for his counsel's services rendered prior to the SAIF Corporation's rescission of its January 21, 1991 compensability denial. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following correction and supplementation. The insurer denied claimant's injury claim on January 21, 1991. Claimant requested a hearing concerning the denial on January 24, 1991. On April 15, 1991, claimant's counsel mailed to SAIF several medical reports, including an April 11, 1991 letter from Dr. Kitchell supporting compensability of claimant's injury. SAIF subsequently accepted claimant's industrial injury claim.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available for SAIF's rescission of its denial. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, section 3. Such is the case here.

We find claimant's counsel to have been instrumental in obtaining compensation. Accordingly, we conclude that an attorney fee is warranted.

After considering the factors set forth in OAR 436-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services in relation to the compensability of claimant's injury to the fingers of her right hand is $800, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue and the value of the interest involved.

Finally, the Referee awarded claimant's counsel an approved attorney fee of 25 percent of the compensation due at the time of the denial, if any. Because we have determined that claimant's counsel is entitled to an assessed fee under ORS 656.386(1), we conclude that a fee under ORS 656.382(2) is no longer warranted, as that statute provides for a fee out of compensation "in all other cases", i.e., in cases in which an attorney fee has not been awarded on another basis. Accordingly, we reverse the Referee's approved attorney fee award.

ORDER

The Referee's order dated May 20, 1990, as reconsidered May 22, 1991, is reversed. That portion of the Referee's order that declined to award an assessed attorney fee for services concerning the SAIF Corporation's rescission of

its denial prior to hearing is reversed. For services rendered in conjunction with the rescission of the denial, claimant's counsel is awarded an assessed attorney fee of $800, payable by SAIF. The Referee's approved attorney fee is also reversed. In other words, claimant's total attorney fee shall not exceed $800. In the event SAIF has already paid all or any portion of the Referee's approved fee award to claimant's counsel, such payments shall be credited against this assessed attorney fee award and SAIF shall reimburse claimant in the amount of the approved fee previously paid, if any.

In the Matter of the Compensation of
GARNET S. STARR, Claimant
WCB Case No. 90-20835
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Davis' order which upheld the self-insured employer's denial of her aggravation claim for her current cervical and thoracic condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In order to prove a claim for aggravation, a claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity since the last award or arrangement of compensation. See Leroy Frank, 43 Van Natta 1950 (1991). The worsening must be more than a waxing and waning of symptoms contemplated by the previous award of permanent disability. ORS 656.273(8). In addition, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1).

The Referee found that there were no persuasive injury-related objective findings to support claimant's complaints of increased symptoms and the worsening of her accepted condition. We agree. Moreover, even if we were to find objective findings to support her claim, claimant has failed to establish a worsening in excess of that contemplated by her previous award.

In this regard, we conclude that the Stipulated Order contemplated future periods of increased symptoms accompanied by a diminished earning capacity. Lucas v. SAIF, 106 Or App 687 (1991); Leonard R. Glazier, 43 Van Natta 2665, 2667 (1991). In August 1989, claimant was examined by Dr. Stewart, orthopedic surgeon, and Dr. Snodgrass, neurologist. (Ex. 116). Drs. Stewart and Snodgrass reported that claimant was experiencing a constant ache, a knot feeling on the right side of the base of her neck, and intermittent pain extending down to the anterior aspect of the right shoulder and upper arm on the right. (Ex. 16-2). Drs. Stewart and Snodgrass noted claimant had subjective residual symptoms. Finally, Drs. Stewart and Snodgrass reported:

> "Because of her repeated injuries occurring at work doing the receiving clerk type of work, it appears prudent that she has now gotten into a job which is of the light duty category. It is our

impression that if she were to receive [sic] to a receiving type of work, she most likely would have increasing exacerbations of symptoms and/or reinjury." (Ex. 16-5).

Further, the October 1989 stipulation provided:

"IT IS FURTHER ORDERED that this award of additional permanent partial disability is intended to compensate claimant for future waxing and waning of the compensable condition . . . " (Ex. 16A-2).

Accordingly, we consider whether claimant's alleged exacerbation was more than a waxing and waning of symptoms contemplated by the Stipulated Order. Lucas v. SAIF, supra.

Claimant relies on a January 1991 letter from Dr. Poul stating that claimant's condition is more than a waxing and waning of her chronic condition. (Ex. 31). However, Dr. Poul's opinion consists of a check-the-box letter. Further, Dr. Poul did not treat claimant before her exacerbation. Accordingly, without additional explanation, we decline to rely upon Dr. Poul's conclusory opinion. See Miller v. Granite Construction Co., 28 Or App 473 (1977); Somers v. SAIF, 77 Or App 259 (1977); Moe v. Ceilings Systems, 44 Or App 429, 433 (9180).

Based upon the medical evidence as a whole, we conclude that claimant has not established that her exacerbation of symptoms was more than that anticipated at the time of her last award or arrangement of compensation. Relying upon the above analysis, as well as the Referee's, we conclude that claimant has not established an aggravation.

ORDER

The Referee's order dated May 1, 1991 is affirmed.

February 25, 1992 Cite as 44 Van Natta 328 (1992)

In the Matter of the Compensation of
KIMBERLY WAYNE, Claimant
WCB Case No. 91-01871
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Menashe's order which found that claimant was not entitled to an assessed attorney fee under ORS 656.386(1) or 656.382(1). On review, the issue is attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

In December 1989, claimant, as part of her job in a fast food restaurant, wore a penguin costume and developed back pain. She saw Dr. Schnacky, chiropractor, who diagnosed a "traumatic lumbosacral and right sacroiliac sprain-strain with radiculitis in the lumbar spine." (Ex. 2).

On December 6, 1990, claimant's attorney notified the employer of the claim and requested that it refer the matter to its carrier for immediate

processing. (Ex. 4A). On December 7, 1990, the employer's manager filed an 801 form for the injury. (Ex. 5).

On December 31, 1990, the insurer notified claimant's attorney that it had not received "any medical records to indicate a diagnosis" and requested any "medical records that you might have." (Ex. 5A).

On January 14, 1991, the Western Medical Consultants performed an independent medical examination and diagnosed "by history, low back pain, improved." (Ex. 6-3).

On January 28, 1991, claimant gave a statement concerning her injury and claim to the insurer. On January 31, 1991, the insurer wrote to Dr. Schnacky "requesting all medical documents relating to [claimant's] injury including chart notes, brief & narrative reports." (Ex. 6A).

On February 7, 1991, the insurer denied the claim because it had "received no medical documentation that medical treatment was provided in reference to the alleged injury December 12, 1989." (Ex. 8-1).

On February 14, 1991, claimant's attorney filed a request for hearing. A hearing was scheduled for March 8, 1991.

On February 12, 1991, Dr. Schnacky responded to the insurer's January 31, 1991 inquiry, stating that he had treated claimant for low back pain that she had sustained while wearing a penguin costume. (Ex. 9). On the basis of the letter and Dr. Schnacky's chart notes, the insurer rescinded the denial on March 1, 1991, and accepted the claim. (Ex. 10).

Although the parties proceeded to hearing, they did not litigate compensability but limited the issues at hearing to attorney fees and penalties.

CONCLUSIONS OF LAW AND OPINION

ORS 656.386(1) Fee

In finding that claimant was not entitled to an assessed attorney fee under ORS 656.386(1), the Referee relied on our order in Duane L. Jones, 42 Van Natta 875 (1990). That order initially was affirmed by the Court of Appeals. Jones v. OSCI, 107 Or App 78 (1991). The court subsequently allowed reconsideration, however, and withdrew its opinion. Jones v. OSCI, 108 Or App 230, 232 (1991). The court's action was based on the 1991 amendment to ORS 656.386(1) providing that if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Id.

The insurer contends that claimant's attorney was not instrumental in obtaining compensation for claimant because, despite requesting medical records from claimant's attorney, the insurer did not receive any documentation or response. Instead, the insurer itself, after learning the name of claimant's treating physician, obtained claimant's medical records by contacting Dr. Schnacky. Claimant disagrees, contending that her attorney was instrumental because he requested a hearing, which prompted the insurer to rescind the denial and accept the claim.

We agree with the insurer that the record establishes that its decision to rescind its denial was not the result of any direct efforts by claimant's attorney. The record before us indicates that the insurer initially denied the claim because it had no evidence that claimant's alleged injury required medical treatment. Further, it was through its own efforts, which were commenced

before claimant's request for hearing, that the insurer obtained Dr. Schnacky's records. The record also indicates that it was Dr. Schnacky's letter and chart notes that caused the insurer to rescind its denial and accept the claim.

However, we nevertheless conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. In this regard, he notified the employer of the claim and requested that it refer the matter to the insurer. In addition, although the request for hearing did not prompt the insurer's rescission of its denial, the request did preserve claimant's right to challenge the denial. Under the circumstances, we conclude that claimant is entitled to an assessed attorney fee under ORS 656.386(1).

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). As set forth above, claimant's counsel's efforts which resulted in obtaining compensation for his client were minimal. In particular, we again note that the record does not establish that any of counsel's services were directly responsible for the insurer's rescission of its denial. Under these circumstances, we conclude that a $350 assessed attorney fee is reasonable.

ORS 656.382(1) Fee

Claimant next asserts that the Referee erred in failing to award attorney fees under ORS 656.382(1) for unreasonable resistance to the payment of compensation. Claimant argues that, even though the insurer was not notified of the claim until December 1990, the insurer should be held accountable under ORS 656.382(1) because the employer failed to take any action regarding claimant's injury until December 1990.

Pursuant to ORS 656.262(10), the Referee awarded claimant a penalty of 25 percent of the compensation that was paid late with one-half of that penalty payable to claimant's attorney. The Referee based this action on the fact that the employer had notice of claimant's injury in December 1989 but failed to notify the insurer until December 1990, creating an unreasonable delay in payment of compensation. Claimant requests an attorney fee under ORS 656.382(1), relying on the same factual basis as that for which the Referee awarded a penalty under ORS 656.262(10).

We have determined, however, that when a penalty is assessed under ORS 656.262(10), we do not also assess an attorney fee under ORS 656.382(1) for unreasonable resistance to payment of compensation if the factual basis for both awards is the same. Otherwise, the legislative intent expressed in ORS 656.262(10) that claimant's attorney receive one-half the penalty "in lieu of an attorney fee" would be contravened. Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry F. Forrester, 43 Van Natta 1480, 1481 (1991). Therefore, having already received a penalty under ORS 656.262(10) for the same conduct, we do not award claimant an attorney fee under ORS 656.382(1).

ORDER

The Referee's order dated May 14, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that declined to award an assessed attorney fee pursuant to ORS 656.386(1) is reversed. For claimant's counsel's pre-hearing services which were instrumental in obtaining compensation for his client, claimant's attorney is awarded a reasonable assessed attorney fee of $350, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ALBERTO C. HERNANDEZ, Claimant
WCB Case Nos. 90-20841 & 90-14190
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for his current low back condition; and (2) declined to award interim compensation. In his brief, claimant alternatively argues that, if he has not established an aggravation claim, he is entitled to medical services for his compensable back and hip injury. Claimant also argues that, if neither his aggravation nor his medical services claim are found compensable, CNA Insurance Companies' denials of his "new injury" claim should be set aside. On review, the issues are aggravation, interim compensation, medical services and compensability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee concluded that claimant had failed to establish a worsening of his condition. We agree, but we base our conclusion upon the following analysis.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the medical worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Claimant contends that, because Dr. Hoppert reported claimant's straight leg raising at 70 degrees bilaterally before the May 1990 incident, the fact that Dr. Hoppert's June 26, 1990 examination demonstrates a straight leg raising of only 45 degrees establishes that claimant's underlying condition has worsened. We disagree. In an aggravation case, we examine whether claimant's condition has worsened since the last award or arrangement of compensation.

Here, claimant's last arrangement of compensation was the July 11, 1986 Opinion and Order which increased his unscheduled permanent disability award from 15 percent to 50 percent unscheduled permanent disability. At that time, the Referee found that claimant's impairment was difficult to ascertain, due to his psychological problems. In determining impairment, the prior Referee relied upon the opinion of Dr. Kiest, who rated claimant's impairment as mild to mildly moderate.

Following claimant's May 1990 incident, Dr. Hoppert, claimant's treating physician, reported that claimant had experienced back pain ever since his 1984

injury. Dr. Hoppert reported that claimant had not changed much over the past several years. On November 8, 1990, Dr. Hoppert reported that claimant had not worsened as a result of his May 9, 1990 work activity and there was no "change in impairment as a result of the same." Dr. Hoppert reported that the incident should be considered as just a "temporary flare or aggravation of his underlying condition."

Consequently, we conclude that there is no evidence that claimant's condition has worsened since his last award of compensation. We, therefore, agree with the Referee that claimant has not established a compensable aggravation.

Interim compensation

We adopt the Referee's Conclusions and Opinion on the issue of interim compensation, with the exception of her conclusion that ORS 656.273(1)(a) is designed to eliminate a finding of worsening based upon symptomatic exacerbations.

Compensability/"New injury" claim

Claimant contends that if his aggravation claim is not found to be compensable, CNA should be found responsible for his "new injury" claim. Claimant argues that, because CNA rescinded its compensability denial at hearing and subsequently denied only responsibility, CNA conceded that claimant's condition was related to his work activity with CNA's insured. Claimant argues that the Referee should not have upheld a compensability denial which had been rescinded.

We agree that, because CNA rescinded its compensability denial, it may not assert a compensability defense on review. See Beverly R. Tillery, 43 Van Natta 2470 (1991); John J. Alcantar, 42 Van Natta 617 (1990). In other words, CNA cannot contend that claimant's condition is not work-related. Accordingly, we agree with claimant that the Referee should not have upheld the rescinded denial of compensability.

We do not agree, however, that because CNA conceded compensability and claimant has not established his aggravation claim against SAIF, CNA is automatically responsible for claimant's "new injury" claim against its insured. See e.g. David D. Allen, 43 Van Natta 2458 (1991)(Until a ".307" order formally issues, compensability remains at issue even though one insurer has indicated its concession that the claim is compensable as to some employer. [Emphasis supplied]). The fact that one potentially responsible party has stipulated that its denial is solely one of responsibility does not alter the fact that compensability remained in issue. Rodney L. Kosta, 43 Van Natta 180 (1991).

We agree with the Referee's conclusion that there is no medical evidence that claimant's two hours of employment with CNA's insured caused any change in claimant's condition. Accordingly, although CNA conceded that claimant's condition was work-related, we find that it is not related to his employment with CNA's insured. We, therefore, affirm the Referee's conclusion that claimant has not established a "new injury" as to CNA.

Medical services

We have concluded that claimant has failed to establish either a compensable aggravation claim against SAIF or a "new injury" against CNA. SAIF, however, remains responsible for claimant's future reasonable and necessary medical services resulting from his compensable 1984 injury.

Finally, we note that there is no basis for an attorney fee award in this case. Claimant has not prevailed on the issues of aggravation or new injury.

Moreover, although we agree that SAIF remains responsible for claimant's future medical services resulting from the compensable injury, our order has not set aside a denial of medical services nor has it resulted in compensation awarded to claimant. See e.g. Lynn M. Elliott, 42 Van Natta 23 (1990). Accordingly, no fee under ORS 656.386(1) is warranted in this case.

ORDER

The Referee's order dated February 12, 1991 is affirmed in part and modified in part. That portion of the Referee's order that upheld the compensability portion of CNA Insurance Companies' denial of June 18, 1990, is modified. The remainder of the Referee's order is affirmed.

February 26, 1992 Cite as 44 Van Natta 333 (1992)

In the Matter of the Compensation of
ROBERT A. LUSK, Claimant
WCB Case Nos. 88-10360, 88-10361 & 88-10362
ORDER ON REMAND
Bennett & Durham, Claimant Attorneys
Roberts, et al., Defense Attorneys
Roy W. Miller (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. BBC Brown Boveri v. Lusk, 108 Or App 623 (1991). The court reversed our prior order, Robert A. Lusk, 42 Van Natta 1584 (1990), that found BBC Brown Boveri (Aetna Casualty Company's insured) responsible for claimant's hearing loss condition from June 23, 1986 to November 15, 1987. In reaching this conclusion, we had found that claimant was employed by BBC on June 23, 1986 and responsible for his hearing loss condition until November 16, 1987, when the condition worsened while claimant was working for Combustion Engineering (CNA Insurance Company's insured). Reasoning that claimant was not performing services for remuneration with BBC when his hearing loss was first discovered, the court concluded that claimant was not a "worker" under ORS 656.005(27) (renumbered ORS 656.005(28)) and that BBC could not have been an employer under ORS 656.005(13). Holding that we erred in setting aside BBC's (Aetna's) denial, finding BBC (Aetna) responsible for claimant's hearing loss claim as of June 23, 1986, and awarding an attorney fee partially payable by BBC (Aetna), the court reversed those portions of our order.

Contending that it "never denied claimant's right to compensation [and] * * * the referee did not make a determination on that issue," Combustion Engineering (CNA's insured) argued that claimant was not entitled to an attorney fee award under ORS 656.386(1). Citing Jones v. OSCI, 108 Or App 230 (1991), the court has remanded that portion of our order which affirmed the Referee's attorney fee award for reconsideration in light of ORS 656.386(1), as amended by Oregon Laws 1991, chapter 312, section 1.

FINDINGS OF FACT

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

Claimant worked in 1987 for Combustion Engineering (CNA's insured). He filed his hearing loss claims with his potentially responsible employers (BBC, Combustion Engineering, and Clark Ullman Welding) in approximately February

1988. On April 13, 1988, an investigator for CNA took claimant's statement concerning his hearing loss claim.

On June 20, 1988, claimant's attorney filed hearing requests concerning claimant's hearing loss claims with the SAIF Corporation, Aetna, and CNA. The hearing requests raised the following issues: compensability; responsibility; and penalties/attorney fees against SAIF and CNA for late denials.

On July 18, 1988, CNA's counsel responded to claimant's hearing request. CNA denied that: (1) claimant sustained a work-related accidental injury or occupational disease; (2) its insured was responsible for the claim; and (3) claimant was entitled to penalties and/or attorney fees.

At hearing, the Referee identified the issues as the appropriateness of Aetna's denial and CNA's "de facto" denial. Claimant's attorney noted that the issues had originally been both compensability and responsibility, but that it was claimant's understanding that only the issue of responsibility was currently unresolved. CNA's attorney responded that claimant's hearing loss was compensable, but that responsibility for the condition remained at issue.

Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

Finding that both Aetna and CNA were responsible for specific periods of claimant's hearing loss condition, the Referee concluded that both carriers were responsible for the condition. The Referee further awarded a carrier-paid fee of $1,800, to be paid in equal portions by the two carriers.

On Board review, we also found that the carriers were responsible for particular periods of claimant's hearing loss disability. In addition, after considering the relevant factors for determining a reasonable attorney fee as set forth in OAR 438-15-010(6) (now section (4)), we found the Referee's $1,800 attorney fee award, equally shared by the two carriers, to be reasonable.

Concluding that Aetna's insured could not have been an employer for claimant, the court has held that Aetna is not responsible for claimant's hearing loss claim. Consequently, the court has determined that we erred in finding Aetna partially responsible for the claim, as well as for an attorney fee award.

CNA also filed a cross-petition for judicial review of that portion of our order which affirmed the Referee's carrier-paid attorney fee award. Asserting that it "never denied claimant's right to compensation [and] * * * the referee did not make a determination on that issue," CNA argued that claimant was not entitled to an attorney fee award under ORS 656.386(1). Citing Jones v. OSCI, supra, the court has remanded for reconsideration of the attorney fee issue in light of ORS 656.386(1), as amended by Oregon Laws 1991, chapter 312, section 1.

In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. ORS 656.386(1). In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. Id.

Effective June 19, 1991, ORS 656.386(1) was amended to further provide that "[i]f an attorney is instrumental in obtaining compensation for a claimant

and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Oregon Laws 1991, chapter 312, section 1. This amendment applies retroactively to cases in which the order was not final on or before the effective date of the Act. Section 3.

CNA contends that claimant is not entitled to an attorney fee under ORS 656.386(1) because CNA never denied compensability of claimant's hearing loss claim. We disagree.

A claim is denied "de facto" after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). See Barr v. EBI Companies, 88 Or App 132, 134 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991). Here, it is not readily apparent when CNA or its insured first received notice of claimant's hearing loss claim. However, at a minimum, CNA had notice of the claim by April 13, 1988, when an investigator on CNA's behalf conducted an interview with claimant concerning his claim. More than 60 days later, on July 18, 1988, claimant's attorney filed a hearing request concerning CNA, raising the issues of compensability, responsibility, penalties, and attorney fees. Moreover, in response to the hearing request, CNA's counsel denied claimant's assertions, including his contention that his claim against CNA was compensable. Under such circumstances, we conclude that CNA denied compensability of claimant's hearing loss claim.

Considering claimant's attorney's July 1988 hearing request concerning claimant's claim with CNA, CNA's response to the hearing request disputing compensability, and CNA's counsel's subsequent statement at hearing that it was not contesting compensability of the claim, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. Consequently, we hold that claimant is entitled to a carrier-paid attorney fee under amended ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(6) (now section (4)) and applying them to this case, we find that a reasonable attorney fee concerning CNA's concession of the compensability issue prior to hearing is $1,200, to be paid by CNA. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of service), the complexity of the issue, and the value of the interest involved.

In addition, we have taken into consideration the court's holding that claimant's hearing loss claim with BBC is not compensable. Consequently, claimant is not entitled to an attorney fee for any efforts devoted to the BBC claim. Finally, we note that claimant's attorney's statement of service was submitted November 17, 1988 (some two months after the hearing), which was shortly after a post-hearing deposition (attended by claimant's attorney) that pertained to the responsibility dispute. Inasmuch as claimant's attorney fee is for services pertaining to CNA's pre-hearing concession of compensability, claimant is not entitled to a fee for such post-hearing services.

Accordingly, on reconsideration, we modify the Referee's attorney fee award as follows. In lieu of the Referee's $1,800 attorney fee award to be paid by Aetna and CNA, claimant's attorney is awarded $1,200, to be paid by CNA Insurance Company. CNA also remains responsible for the Referee's $200 attorney fee award for a "late denial."

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT E. RIEGEL, Claimant
WCB Case No. 90-21453
ORDER ON RECONSIDERATION
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

The self-insured employer requests reconsideration of that portion of our January 30, 1992 order that affirmed the Referee's determination that claimant's attending physician, Dr. Brookhart, verified claimant's inability to work due to his work-related condition from August 29, 1990, through October 30, 1990. On reconsideration, the employer challenges our order on two bases. First, the employer renews its contention that verification of inability to work requires "objective" medical findings. Further, it contends that because claimant submitted a mental stress claim, the opinions of Internist Dr. Brookhart, "who is qualified only as a dermatologist," cannot constitute the opinions of the "attending physician" as required by ORS 656.262(4)(b).

Having received claimant's reply to the employer's request for reconsideration, we proceed to our review on reconsideration.

After reviewing claimant's reply and the employer's motion and memorandum in support, we conclude that our January 30, 1992 Order on Review adequately addresses the employer's contention that verification of inability to work requires "objective" medical findings.

On reconsideration, the employer now asserts that because Dr. Brookhart is an Internist specializing in dermatology, he does not qualify as an attending physician for claimant's mental condition and, therefore, no verification of claimant's inability to work was received from an attending physician. We find this analysis without merit. Here, the employer repeatedly wrote to Dr. Brookhart and reminded him of his duties as claimant's attending physician to assist in facilitating reports from consulting mental health care providers. At hearing, the claims adjuster unequivocally testified that the employer considered Dr. Brookhart to be claimant's attending physician for the time period at issue. Moreover, we note that the employer objected to the admission of chart notes from claimant's psychologist/specialist because he is an out-of-state non-attending physician.

More importantly, Oregon courts have held that a physician is not incompetent to render a medical opinion merely because he is not a specialist in the particular field involved in the case. See Barrett v. Coast Range Plywood, 294 Or 641 (1983; Thomas v. Liberty Mutual Insurance, 73 Or App 128 (1985); Mollie E. Barrow, 43 Van Natta 617 (1991). The fact that Dr. Brookhart is not a psychologist or psychiatrist has no effect on whether he is qualified to render an opinion regarding claimant's inability to work during the time period at issue in this case.

We have found no authority that holds that a physician must be a psychologist or psychiatrist in order to serve as an attending physician for a claimant with a mental disorder. On this record, we find that Dr. Brookhart is claimant's attending physician.

Finally, claimant's counsel is entitled to an assessed attorney fee, in addition to the attorney fee assessed by our January 30, 1992 order, for additional services relating to the employer's request for reconsideration. See 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 in responding to the employer's motion is $200. In reaching this

conclusion, we have particularly considered the time devoted to the issue and the value of the interest involved.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our January 30, 1992 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TAMARA E. THOMPSON, Claimant
WCB Case No. 90-14471
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Otto's order that upheld the self-insured employer's partial denial of claimant's esophagitis and skeletal chest pain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact," with the following correction. Claimant compensably injured her back and neck on March 28, 1989, rather than on March 28, 1990.

In addition, we supplement with the following. In October 1989, claimant entered an alcohol recovery program. She took no drugs as a part of this treatment.

Claimant filed her request for hearing on July 11, 1990; the hearing was held on November 30, 1990.

ULTIMATE FINDINGS OF FACT

Claimant's compensable back and neck injury, which resulted in her use of large doses of pain reliever, is the major contributing cause of her consequential esophagitis and skeletal chest pain.

CONCLUSIONS OF LAW

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

ORS 656.005(7)(a)(A) provides, in relevant part, that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the

compensable injury is the major contributing cause of the consequential condition." See Julie K. Gasperino, 43 Van Natta 1151 (1991) (providing that a "consequence" normally relates to a claimant's condition which occurs as a result of the injuries sustained in an industrial accident, as distinguished from a condition directly arising from the industrial accident itself).

The issue of whether claimant's esophagitis and skeletal chest pain condition was caused in major part by her back and neck injury is a complex medical question. Thus, although claimant's testimony is probative, 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).

Only Drs. Miller and Richards address the issue of causation, and both attribute claimant's esophagitis and skeletal chest pain to her ingestion of large quantities of ibuprofen for relief of back pain. After performing a complete examination and review of claimant's medical history, Dr. Richards concludes that claimant has gastritis, probably related to the medications "being taken for her muscular problems." Similarly, Dr. Miller states that the "exclusive" or a "substantial contributing" cause of claimant's esophageal symptoms is her use of ibuprofen.

The Referee first discounted the opinion of Dr. Miller, claimant's treating physician for the denial conditions, as contradictory. We do not agree. We find Dr. Miller's initial response concerned a direct relationship between claimant's consequential condition and work. Dr. Miller correctly noted no direct relationship between the two. Here, however, the causal link is indirect: ibuprofen, rather than claimant's back and neck injury, caused her esophagitis and skeletal chest pain. Thus, we find no inconsistency between Dr. Miller's reports.

The Referee further found neither Dr. Miller's nor Dr. Richards' opinion persuasive because neither physician discusses the effect of claimant's drug and alcohol recovery program on her esophagitis. However, both doctors are aware of claimant's use of alcohol and entrance into an alcohol recovery program, but did not mention it as a cause of her condition. Moreover, there is no evidence, nor even suggestion in this record from any medical source, that claimant's drug and alcohol treatment program contributed to her esophagitis and skeletal chest pain. On the unrebutted evidence in this record, we decline to so speculate.

In summary, Dr. Richards' and Dr. Miller's opinions attribute claimant's condition to her use of ibuprofen. See McClendon v. Nabisco Brands, 77 Or App 412 (1986) ("magic words" not required). No medical opinions attribute her condition to any other cause(s). Consequently, claimant has carried her burden, and established that the compensable back and neck injury is the major contributing cause of her consequential esophagitis and skeletal chest pain.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,400, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by the hearing record and appellant's brief, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 7, 1990 is reversed. The self-insured employer's denial is set aside, and the claim is remanded to the employer for processing in accordance with the law. For his services at hearing and on review, claimant's counsel is awarded a reasonable assessed fee of $2,400, payable by the self-insured employer.

In the Matter of the Compensation of
ROSE D. TUTTLE, Claimant
WCB Case No. 91-04482
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Knapp's order which: (1) found that SAIF was precluded from denying claimant's current psychological condition; and (2) set aside its denial of claimant's psychological condition claim. On review, the issues are the res judicata effect of a prior order which directed SAIF to accept a claim for depression and, if SAIF is not precluded by res judicata, compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee concluded that SAIF was precluded from denying medical services for claimant's schizoaffective disorder because an earlier Referee's order found claimant's "depression" to be compensable. The Referee specifically found that the schizoaffective disorder was the prior accepted condition and that the evidence established that claimant's work stress was the major contributing cause for the symptomatic increase in the underlying disorder.

We agree with the Referee's analysis that a determination of whether res judicata precludes SAIF from denying claimant's current condition requiring medical treatment depends on whether her current diagnosis of schizoaffective disorder refers to her prior accepted condition of bipolar depression. If they are the same, then issue preclusion would apply since the compensability of claimant's condition was actually litigated in the prior 1985 order. See North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). If they are not the same, res judicata would not preclude litigation of the compensability of claimant's current condition. Specifically, issue preclusion would not apply since a prior order would not have actually litigated the compensability of the schizoaffective disorder; claim preclusion would not apply since the factual transaction at issue in the prior order did not concern those facts relating to claimant's current condition. See Drews v. EBI Companies, 310 Or 134, 140 (1990). We therefore proceed to review the medical evidence relating to claimant's condition at the time of the 1985 order and her current condition.

Claimant first sought psychiatric treatment in 1984. She subsequently filed, and was denied, a claim for "severe anxiety reaction." (Ex. 2). In June 1985, SAIF was ordered to accept a claim for "depression." (Ex. 2C-5). The order was based largely on the report of Dr. Tallman, treating psychiatrist. Tallman diagnosed "bipolar depression" and stated that its cause was "partially genetic." (Ex. 2B-2). Tallman further found, however, that "there is no doubt that [claimant's] social and professional interactions, her environment that is, have contributed to the aggravation of the condition and certainly I think that her job situation * * * has definitely aggravated her mood disorder." (Id.)

In September 1987, claimant began treating with Dr. Erkkila, psychiatrist. Erkkila diagnosed post-traumatic stress disorder secondary to a traumatic childhood and further aggravated by the job stress. (Ex. 3-3). For the first time, a separate underlying schizoaffective disorder also was noted. (Id.)

Pursuant to a June 1988 Referee's order, claimant was awarded 65 percent permanent partial disability. In the opinion providing for this award, the Referee noted the various diagnoses made by Dr. Erkkila, stating that "only the post-traumatic stress related to claimant's job loss is compensable." (Ex. 6-2). That order was affirmed by the Board. (Ex. 9).

In 1989, claimant began treating with Dr. Satterwhite, Ph.D. He agreed with Dr. Erkkila that claimant suffered from post-traumatic stress resulting from job stress and job loss. (Ex. 11). He described her symptoms as "abnormal anxiety reactions to situations which directly and metaphorically relate back to original job stress and job loss." (Id.)

Claimant's current treating physician is Dr. Stevens, psychiatrist. He diagnosed claimant as suffering from schizoaffective disorder. (Ex. 16). Moreover, Stevens reports that "one can with certainty say that [claimant] does not suffer from post-traumatic stress disorder." (Ex. 22-2).

This opinion was reiterated by Dr. Binder, Ph.D., and Dr. Turco, psychiatrist, both of whom conducted independent medical examinations. Dr. Binder agreed with the diagnosis of schizoaffective disorder, stating that "[n]o doubt the on-the-job stressors in 1983-1984 made her symptomatology worse temporarily. Now, however, she is dealing with the effects of a chronic psychiatric illness which bears no resemblance to a Post Traumatic Stress Disorder. A diagnosis of Post Traumatic Stress Disorder seems entirely inappropriate." (Ex. 17-7). Dr. Turco also found that claimant's current condition was biological and genetic in nature, and not work-related. (Ex. 18-5).

The only evidence addressing whether the schizoaffective disorder refers to the same condition as bipolar depression is from Dr. Stevens, who states that Dr. Tallman's records "indicate that in fact schizoaffective disorder may have been the most appropriate diagnosis for the condition that he was describing." (Ex. 22-1). Given the lack of conviction of this statement, we are essentially faced with the difficult task of determining whether one psychiatrist's 1984 diagnosis of "bipolar depression" refers to the same condition as another psychiatrist's 1990 diagnosis of "schizoaffective disorder." This determination is made all the more difficult given that claimant from the outset has been diagnosed as suffering from a preexisting psychiatric condition, as well as subsequently diagnosed with a multitude of conditions, including post-traumatic stress syndrome, alcohol dependence, an organic brain syndrome, and schizoaffective disorder.

After considering the physicians' reports and prior Referee orders, we are persuaded that claimant's condition, which was deemed compensable in 1985, is not the same condition for which she is currently being treated. To begin,

claimant's symptoms are different now from what she presented at the time of the 1985 order. That order noted symptoms of nausea, dizziness, and diarrhea, as well as night sweats, tremulousness, extremity pains, and nightmares. (Ex. 2C-3-4). Dr. Stevens has noted none of those symptoms, instead describing claimant as having auditory hallucinations, thought disorganization, (Ex. 14-6), and mood instability, (Ex. 16).

Moreover, all of claimant's prior treating physicians focused their treatment at least in part on her work experience; all the physicians attributed at least some of claimant's symptoms to her work experience and their treatment in part was to alleviate claimant's stress relating to her job. Dr. Stevens, on the other hand, has not shown that his treatment in any way relates to claimant's experience in her job. To the contrary, Stevens' reports indicate that he has not even discussed the job experience with claimant, since he states that, "[h]aving only the newspaper accounts and letters associated with the episode surrounding [claimant's] difficulties in that work situation, obviously there are many things I cannot say about that situation[.]" (Ex. 22-2).

We also note that Dr. Binder and Dr. Turco, both of whom examined claimant in March 1991, found that, although job stress temporarily caused some symptomatology, those stressors had long ago dissipated and her condition could no longer be attributed to her work experience.

In view of the paucity of medical evidence showing that claimant's condition in 1985 is the same as her current condition, as well as the difference in symptoms and focus of treatment, we conclude that the condition currently being treated is different from that previously ordered to be accepted.

We also are convinced that the 1988 Referee's order providing for a permanent partial disability award does not preclude litigation concerning the compensability of claimant's current condition. Although the order did not directly relate to compensability, the Referee was required to determine which of claimant's conditions was compensable in order to rate unscheduled disability. In making this determination, the Referee expressly found only the post-traumatic stress syndrome to be compensable. We therefore proceed to address the compensability of claimant's schizoaffective disorder.

Compensability

Claimant's schizoaffective disorder allegedly either resulted as a consequence of her compensable stress claim or has combined with her compensable claim. Under ORS 656.005(7)(a)(A), "no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." In Julie K. Gasperino, 43 Van Natta 1151, 1153 (1991), we held that the "major contributing cause" standard required by ORS 656.005(7)(a)(A) applies to "secondarily consequential conditions" while the "material contributing cause" standard remains to prove "primarily consequential conditions."

Similarly, under ORS 656.005(7)(a)(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."

The medical evidence concerning the cause of claimant's disorder consists of a report from Dr. Stevens. He concedes that "schizoaffective disorder has a genetic component, and given [claimant's] family history, it is highly likely that she has a genetic vulnerability to this disorder. However, it is not

reasonable to conclude that this is the sole cause of her disorder." (Ex. 22-1). Stevens goes on to state that, "given the absence of evidence for the presence of that disorder prior to that intense work stress, given recent evidence about the interaction of biological and environmental factors in the precipitation of both mood and schizophrenic disorders, in my opinion it is reasonable to conclude that her disorder, although chronic in nature, was in fact precipitated by the work stress." (Id. at 2).

We find Stevens' opinion to be unpersuasive. Stevens did not begin treating claimant until December 1989, five years after claimant was fired from her job. By contrast, Dr. Erkkila, who began treating claimant nearly three years earlier (Ex. 13), diagnosed an underlying schizoaffective disorder which rendered claimant more vulnerable to work stress. Moreover, Stevens exhibits little knowledge of claimant's work experience; as stated above, there is little evidence that Stevens' treatment relates to the job and Stevens states that his knowledge concerning the job is based on letters and newspaper accounts.

Furthermore, the remaining medical evidence supports the conclusion that claimant's schizoaffective condition is genetically caused. This opinion was stated by Dr. Erkkila, as well as Dr. Binder and Dr. Turco. Dr. Stevens also recognizes the genetic factor, although he makes no attempt to quantify its impact in relation to environmental factors.

In short, whether analyzed as a consequential condition or as a preexisting condition combining with her compensable claim, we find the evidence insufficient to prove that claimant's schizoaffective disorder is compensable.

ORDER

The Referee's order dated July 30, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's assessed fee award of $1,750 to claimant's attorney is reversed.

February 27, 1992 Cite as 44 Van Natta 342 (1992)

In the Matter of the Compensation of
STEVEN V. BISCHOF, Claimant
WCB Case No. 90-10882
ORDER OF ABATEMENT
Sellers & Jacobs, Claimant Attorneys
Cooney, et al., Defense Attorneys

Claimant requests reconsideration of our February 14, 1992 Order on Review. The self-insured employer has filed a response to claimant's motion. In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHARON M. BREWER, Claimant
WCB Case No. 90-02266
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of Referee Kinsley's order that: (1) increased claimant's unscheduled permanent disability award for a right shoulder condition from 5 percent (16 degrees), as awarded by Determination Order, to 14 percent (44.8 degrees); (2) increased claimant's scheduled permanent disability award for her right arm condition from 9 percent (13.5 degrees), as awarded by Determination Order, to 41 percent (78.72 degrees); and (3) increased claimant's scheduled permanent disability award for her left arm condition from 5 percent (7.5 degrees), as awarded by Determination Order, to 38 percent (72.96 degrees). On review, the issue is extent of unscheduled and scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled permanent disability

The employer does not contest the Referee's assigned values for age, education, skill, training and adaptability. We agree with the Referee's assigned values and adopt her conclusions and opinion in that regard. Accordingly, on review, we address only the issue of impairment.

The employer contends that the Referee should not have awarded a value of 5 percent for a chronic condition limiting repetitive use of the shoulder. The employer contends that, although Dr. Steele checked a box stating that claimant could "occasionally" reach above shoulder level, such a report does not establish a chronic condition. The employer notes that Dr. Steele's closing exam found that claimant suffered limitations only in her hands and arms.

We agree with the employer's contention that, in itself, Dr. Steele's "check-the-box" restriction of claimant's lifting above shoulder level to "occasionally" does not establish that claimant has a chronic shoulder condition limiting repetitive use. This is particularly true given the fact that Dr. Steele's narrative report accompanying the physical capacities evaluation notes no shoulder complaints or limitations. Accordingly, we reverse the Referee's award of 5 percent for a chronic right shoulder condition. Claimant's total impairment value for the shoulder, therefore, is 5. Former OAR 436-35-330(14).

Claimant's age value, 0, is added to her education value, 4, for a sum of 4. When that value is multiplied by claimant's adaptability value, 1, the product is 4. When that value is added to claimant's impairment value, 5, the result is 9 percent unscheduled permanent disability. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the standards is, therefore, 9 percent.

Scheduled permanent disability

We agree that the Referee correctly deferred to the opinion of Dr. Steele, claimant's treating physician, on the issue of causation of claimant's Raynaud's phenomenon and we adopt the Referee's reasoning on that issue. We also adopt the Referee's assigned impairment values of 35 for each arm for claimant's Raynaud's phenomenon condition. Former OAR 436-35-110(6)(c).

Finally, the employer contends that the Referee erred in assigning a 5 percent impairment value for decreased sensation over the scar on claimant's right palm. Former OAR 436-35-110(1)(e) provides that "[c]omplete loss of sensation in the entire palm is rated at 50 percent of the hand." The employer argues that claimant suffers only some loss of sensation in part of her palm, rather than complete loss of sensation in her entire palm. Claimant contends that the rule should be interpreted to provide for a maximum award of 50 percent when the loss is complete; however, when the loss is less than complete, a proportional award should be made.

We agree with claimant. The applicable "standards" expressly provide that, where a maximum value is given for a complete loss of use or function, a percentage of that figure shall be given for less than complete loss. Former OAR 436-35-010(4). Accordingly, we agree with the Referee's interpretation of the rule and her proportional award of 5 percent loss of the hand, which is converted to 4 percent loss of the arm. Former OAR 436-35-110(1)(e) and former 436-35-090(1).

Claimant's total scheduled award of 41 percent permanent partial disability for her right arm and 38 percent permanent partial disability for her left arm is affirmed.

Because the employer requested the reduction of claimant's scheduled permanent disability award as granted by the Referee, and we have affirmed that portion of the Referee's order, claimant is entitled to a reasonable attorney fee pursuant to ORS 656.382(2). See Kordon v. Mercer Industries, 308 Or 290 (1989). 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 on Board review concerning the issue of extent of scheduled disability is $800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated May 6, 1991, as amended by the May 8, 1991 order, is modified in part and affirmed in part. In lieu of the Referee's award and in addition to the Determination Order award of 5 percent (16 degrees) unscheduled permanent disability for her right shoulder, claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability, giving her a total unscheduled permanent disability award for the right shoulder of 9 percent (28.8 degrees). The Referee's attorney fee award is accordingly modified. The remainder of the Referee's order is affirmed. For services on review concerning the issue of extent of scheduled permanent disability, claimant's counsel is awarded a reasonable assessed fee of $800, to be paid by the self-insured employer.

In the Matter of the Compensation of
DEBBIE L. BROWN, Claimant
WCB Case No. 88-19187
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Brown v. Gold Beach Dairy Queen, 109 Or App 499 (1991). The court has reversed our prior order which had affirmed a Referee's order that affirmed a Determination Order awarding no additional scheduled permanent disability for claimant's left knee beyond her prior awards totalling 30 percent (45 degrees). In reaching our conclusion, we found that claimant was entitled to an award of 10 percent disability for disabling pain. Combining this 10 percent disability with claimant's 1.7 percent disability for reduced range of motion, we reasoned that claimant had not established by clear and convincing evidence that she had lost more than the 30 percent use and function of her left knee recognized by her prior awards. On appeal, the parties agreed that our order did not provide an ordered set of findings and a reasoned explanation of why claimant's disabling pain causes only a 10 percent loss of use and function. Finding nothing in our order that would justify our failure to provide such an explanation, the court remanded for reconsideration.

On reconsideration, we adhere to and republish our prior order with the following supplementation.

Claimant's left knee claim was reopened in March 1988. In April 1988, she underwent an arthroscopy by Dr. Freudenberg, orthopedist. Freudenberg also performed a patellar shave, a screw removal, and a lateral and retinacular release.

In July 1988, Dr. Barton, chiropractor, estimated claimant total impairment to be in the range of 15 to 20 percent. Barton attributed this impairment to pain, crepitus, and weakness. Dr. Freudenberg concurred with Dr. Barton's findings.

Claimant was last examined by Dr. Freudenberg in September 1988. Freudenberg prescribed a patella knee brace and scheduled a "re-check" examination in one month. No pain medication was prescribed. Claimant did not return for a re-examination.

Claimant experiences left knee pain "just all over basically, mostly on the side." This pain increases with her activity and limits her ability to perform household and work duties. She also experiences swelling and grating. Claimant does not take pain medication.

Under former OAR 436-35-010(2), disabling pain can result in loss of use or function and an impairment value may be awarded, even though the standards do not provide for a value range for impairment attributable to disabling pain. Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325 (1992), citing Daniel M. Alire, 41 Van Natta 752, 757 (1989). Furthermore, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than that indicated by the "standards." Former ORS 656.283(7); 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).

Here, the medical and lay evidence establishes that claimant suffers disabling pain as a result of her 1984 compensable injury and subsequent surgeries.

After reviewing this record, we are persuaded that claimant's pain does not exceed a maximum of 20 percent impairment. In reaching this decision, we rely on the findings and conclusions of Dr. Barton, as concurred in by Dr. Freudenberg, claimant's treating surgeon. Claimant's testimony demonstrates that her pain has limited the use and function of her left knee. Nevertheless, despite her pain complaints, we note that claimant neither returned to Dr. Freudenberg for re-examination as previously directed nor has she taken pain medication.

When claimant's disabling pain value (20) is combined with her reduced range of motion value (1.7), the total is 22 percent. See former OAR 436-35-240(5). Consequently, claimant's scheduled permanent disability award under the "standards" is 22 percent. Inasmuch as claimant has previously received 30 percent scheduled permanent disability for her left knee, she is not entitled to an additional award under the "standards" as a result of this most recent closure of her claim. Ronald R. Buddenberg, 43 Van Natta 434 (1991); Gary A. Koch, 42 Van Natta 2777 (1990).

As noted above, claimant may establish that the record, as a whole, constitutes clear and convincing evidence that her permanent partial disability exceeds the 30 percent scheduled award that she has been previously granted. Based on the conclusions and reasoning discussed earlier, this record does not establish that it is "highly probable" that claimant's scheduled permanent disability award exceeds her previously granted 30 percent award. Consequently, we are not persuaded that claimant has proven by clear and convincing evidence that she has suffered a loss of use or function of the left knee in excess of the 30 percent scheduled permanent disability award that she has been previously granted.

Accordingly, on reconsideration, we affirm the Referee's order dated May 3, 1989.

IT IS SO ORDERED.

February 27, 1992 Cite as 44 Van Natta 346 (1992)

In the Matter of the Compensation of
DENNIS C. BUSH, Claimant
WCB Case No. 90-19369
ORDER ON RECONSIDERATION
Schouboe & Furniss, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of our January 28, 1992 Order on Review. On February 14, 1992, we abated our order to allow claimant an opportunity to respond. Claimant's response has been received.

The insurer contends that we erred in calculating the values for claimant's impairment, adaptability and skills. The insurer's arguments regarding the impairment and adaptability values were adequately addressed in our initial Order on Review. Therefore, on reconsideration we address the insurer's arguments only with regard to the skill value.

In our initial order, we found that the highest SVP level demonstrated by claimant for the ten-year period preceding the hearing was an SVP value of 4 for a truck driver, flatbed (DOT 905.663-014). The insurer argues that claimant worked as a shipping and receiving clerk (DOT 222.387-050) from 1982 through 1984. (Ex. 18-3). Thus, the insurer argues, claimant's highest SVP value was 5, resulting in an age/education component of 2.

The record does not indicate that claimant has worked as a shipping and receiving clerk. Instead, the record indicates that claimant worked in "shipping and receiving" and as a "shipping and receiving/laborer." (Exs. 1, 18-3). The DOT describes a shipping and receiving clerk as a clerical job. However, the record does not establish that any of claimant's work in the shipping and receiving positions involved clerical work. Instead, we find that the job of material handler (DOT 929.687-030) most closely describes those positions. (Exs. 1, 18, Tr. 13). Material handler has an SVP value of 3. Therefore, we adhere to our finding that the SVP value of 4 for claimant's job as truck driver, flatbed represents the highest SVP level demonstrated by claimant for the ten year period preceding the hearing.

Finally, claimant's counsel is entitled to an assessed attorney fee, in addition to the attorney fee assessed by our January 28, 1992 order, for additional efforts on Board review concerning the insurer's request for reconsideration. 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 in responding to the insurer's motion is $200. In reaching this conclusion, we have particularly considered the time devoted to the issues and the value of the interest involved. Accordingly, claimant's counsel is awarded an additional assessed fee of $200, to be paid by the insurer.

Accordingly, our January 28, 1992 Order on Review as supplemented herein, is republished in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 27, 1992 Cite as 44 Van Natta 347 (1992)

In the Matter of the Compensation
LETICIA T. DURAN, Claimant
WCB Case No. 90-13868
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Spangler's order that affirmed a Determination Order which awarded no scheduled permanent disability for a right leg (knee) injury. On review, claimant presents additional evidence. We treat such as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). The issues on review are remand and extent of scheduled permanent partial disability. We deny the request for remand and modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

With her brief, claimant has submitted a report dated May 17, 1991, from Dr. Hunt, examining orthopedist, and requests that the report be entered into the record. In the alternative, claimant requests that this case be remanded for consideration of this additional evidence. We deny claimant's request.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

We find that the record is not insufficiently developed without the report submitted by claimant on review. The record includes two reports from Dr. Steele, treating orthopedist, which detail the extent of claimant's permanent disability. Further evidence on extent of disability would be cumulative. Furthermore, the document claimant submits addresses her condition almost two months after hearing. Therefore, this document is not materially relevant to the extent of claimant's disability at the time of hearing. See Gettman v. SAIF, 289 Or 609 (1980). Accordingly, we conclude that the record has not been improperly, incompletely or otherwise insufficiently developed and deny claimant's motion to remand this case for admission of further evidence. Mark A. Ostermiller, 42 Van Natta 2873 (1990).

Extent of Scheduled Permanent Partial Disability

The Referee affirmed the Determination Order which awarded no scheduled permanent disability for claimant's right leg (knee) injury. We modify.

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; WCD Admin. Order 1-1989.

Claimant argues that atrophy and knee instability noted in a November 1989 report from Dr. Steele entitle her to an impairment value from 15 to 20 percent. We disagree. This report related to claimant's condition well before she became medically stationary on May 5, 1990. These pre-medically stationary findings are not ratable.

Relying on an April 5, 1990 report from Dr. Steele, claimant argues that she is entitled to 4 percent impairment for the loss of flexion in her right knee. (Ex. 21). We disagree. We determine disability at the time of the hearing. Gettman v. SAIF, supra. In a February 26, 1991 examination, less than a month before the hearing date, Dr. Steele noted that claimant had a full range of motion in her right knee. (Ex. 12A-5). Thus, claimant is not entitled to any impairment value for loss of range of motion.

Finally, claimant argues that she is entitled to 5 percent impairment for a chronic condition limiting repetitive use of her right knee. We agree. Dr. Steele opined that claimant was permanently limited in her ability to squat and bend. (Exs. 12A-5, 12A-6). This opinion is unrebutted. Dr. Steele's reports as a whole relate this limitation to claimant's right knee injury.

The record indicates that claimant presented hysterical-type symptoms during her examination by the Western Medical Consultants and during her initial examination by Dr. Steele. However, there is no persuasive evidence that Dr. Steele's opinion relating to claimant's loss of repetitive use is not accurate because of these hysterical-type symptoms. (Exs. 15, 19-1, 20). Accordingly, we find that claimant has proven entitlement to an award of 5 percent scheduled

permanent disability for loss of use or function of the right knee. Former OAR 436-35-010(7).

ORDER

The Referee's order dated April 17, 1991 is modified. Claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee). This represents her total award to date. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The insurer is authorized to offset its $3,569.59 overpayment of temporary total disability benefits against this award and future awards, if any, of permanent disability. The remainder of the order is affirmed.

February 27, 1992 Cite as 44 Van Natta 349 (1992)

In the Matter of the Compensation of
DOTTY C. FOWLER, Claimant
WCB Case No. 91-15570
ORDER OF DISMISSAL (REMANDING)
Scott M. McNutt, Claimant Attorney
Foss, et al., Defense Attorneys

The insurer has requested and claimant has cross-requested Board review of Referee Livesley's February 11, 1992 "Order Denying Motion." We have reviewed the request to determine whether we have authority to consider this matter. Because we conclude that the Referee's order is not a final order, we dismiss the request for review.

FINDINGS OF FACT

In October 1991, claimant requested a hearing. Claimant raised the following issues: (1) premature claim closure; (2) aggravation; and (3) unscheduled permanent disability resulting from an April 6, 1991 Reconsideration Order.

A hearing was scheduled for January 23, 1992. At the time of hearing, the insurer moved for dismissal of claimant's request for hearing concerning the extent of permanent disability resulting from the low back and aggravation for that condition. The insurer contended that the Referee lacked jurisdiction to consider those issues because a Determination Order granting permanent disability for the low back was void since the insurer had never accepted the condition.

On February 11, 1992, the Referee issued an "Order Denying Motion." The Referee denied the insurer's motion to dismiss claimant's request for hearing. Furthermore, the Referee directed that the issues "raised by claimant's October 25, 1991, request for hearing shall be rescheduled for hearing in Coos Bay, Oregon, before the next available referee."

FINDINGS OF ULTIMATE FACT

The Referee's February 11, 1992 "Order Denying Motion" did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an

appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, the Referee's February 11, 1992 order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order was interim in nature in that it addressed a procedural issue (the insurer's motion to dismiss). Furthermore, upon denial of that motion, the Referee directed that claimant's hearing request be rescheduled for a future date. At this rescheduled hearing, evidence concerning the issues raised by claimant's hearing request will be presented.

Consequently, as a result of the Referee's decision regarding the insurer's procedural motion, further proceedings will be required to determine claimant's entitlement to, and/or the amount of, compensation. Such a procedure is in keeping with the Board's interest in avoiding piecemeal review of multiple issues arising in a single case. Maria Martinez, 40 Van Natta 57 (1988).

Inasmuch as further action before the Hearings Division is required as a result of the Referee's order, we conclude that it is not a final order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Therefore, we lack jurisdiction to consider the insurer's request and claimant's cross-request for Board review.

Accordingly, this case is returned to the Presiding Referee for further action consistent with this order and the Referee's February 11, 1992 "Order Denying Motion." In other words, to reschedule a hearing concerning the matters raised by claimant's hearing request.

IT IS SO ORDERED.

In the Matter of the Compensation of
BILLY J. KING, Claimant
WCB Case Nos. 91-01635 & 90-20356
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

The SAIF Corporation requests review of that portion of Referee Harri's order that: (1) set aside SAIF's denial of claimant's "new injury" claim for a low back condition; and (2) upheld Fireman's Fund Insurance Company's denial of claimant's aggravation claim for the same condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his low back in 1986 while working as a choker setter for Fireman's insured. In 1987, he underwent surgery for a central L5-S1 herniated nucleus pulposus. A July 1988 Determination order awarded 9 percent unscheduled permanent disability. This award was affirmed by a September 1988 Referee's order.

The Referee in that case found claimant not credible because claimant was not forthright in responding to questions regarding his "off-the-job activities." (Ex. 18). Furthermore, the earlier Referee noted that, after viewing a

video tape of claimant water skiing on September 3, 4 and 5, 1988, Dr. Grant, who was claimant's treating physician then, concluded that there was a "severe discrepancy" between claimant's high level of physical activity evidenced in the water skiing video and the back pain and discomfort claimant had previously reported to him. (Ex. 19 and 20).

Claimant continued to experience low back complaints. In 1989, claimant began working for SAIF's insured as an insulation installer. His job involved repetitive lifting, climbing, twisting and bending.

During the summer of 1990, claimant lifted weights three to four times a week. (Tr. 39-41). He also went water skiing "a lot." (Tr. 45).

In the later part of that summer, claimant began experiencing severe pain in his low back. On October 12, 1990, he sought treatment for the first time from Dr. Webb, a neurosurgeon. Claimant's reported history of his back condition did not include his weight lifting and water skiing activities. (See Exs. 24, 29, 33 and 34). Tests revealed a mild bulging of the L5-S1 disc. (Ex. 25).

Dr. Webb referred claimant to Dr. Campagna, also a neurosurgeon, who surgically removed a large extruded disc fragment from claimant's back at the L5-S1 level. (Ex. 40). In addition to describing his work activities as an insulation installer, claimant told Campagna that on October 11, 1990 he was lifting insulation at work and was hit in the back by an insulation ball. (Ex. 35). Claimant did not tell Dr. Campagna about his weight lifting and water skiing activities. (See Exs. 38-42, 47 and 48).

CONCLUSIONS OF LAW AND OPINION

We note at the outset that claimant requested a hearing in this matter after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, we apply the 1990 amendments to the workers' compensation law. Or Laws 1990 (Special Session), ch. 2, section 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

At hearing, claimant advanced two theories of compensability. He alleged that his back condition was either the result of being hit in the back by an insulation ball on October 11, 1990 while working for SAIF's insured or caused by his work activities for that employer. The Referee concluded that claimant's back condition was compensable because his work activities as an insulation installer were the major contributing cause of his current disability and need for surgery.

On review, SAIF contends that claimant's condition is not compensable because his weight lifting and water skiing activities were the major contributing cause of his current back condition. We conclude that claimant has failed to prove that his work activities for SAIF's insured were the major contributing cause of his back condition and need for surgery.

To establish the compensability of his occupational injury claim under ORS 656.802, claimant must prove that his work activities were the major contributing cause of his low back condition or its worsening. Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). In light of claimant's prior surgery and similar low back complaints, we find that the causation issue is a complex medical question requiring for its resolution expert medical evidence. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publisher's Paper Co., 76 Or App 105 (1985).

The Referee found that claimant's testimony was "evasive" and "argumentative." Nevertheless, he concluded that claimant's condition was caused by his work activities, relying on the testimony of Lorel Hahn and on the expert medical opinions of Dr. Webb, claimant's treating physician, and Dr. Campagna, claimant's treating surgeon. SAIF argues on review that the Referee erred in finding Hahn was a credible witness because she was biased and testified as she did because she was afraid of claimant. We need not address that argument because, even assuming that Hahn was credible, her testimony indicates that she did not know about claimant's water skiing and weight lifting activities, which were confirmed by Thomas Stephens, claimant's friend and co-worker, and by claimant's own admissions.

At hearing, Hahn testified that claimant did not water ski that summer. (Tr. 48). However, by claimant's own admission, he did water ski. (Tr. 105). Moreover, Stephens credibly testified that claimant said he went water skiing "a lot" that summer. (Tr. 45). Additionally, while Hahn simply stated that she had "never noticed him doing it" (Tr. 51), Stephens verified that claimant was a regular weight lifter during the summer of 1990 and that he lifted, by claimant's own admission to Stephens, three to four times a week. (Tr. 39-41).

SAIF further contends that we should find Dr. Webb's and Dr. Campagna's opinions unpersuasive because their opinions are based on an inaccurate medical history. We agree.

While we generally give great weight to the opinions of the treating physicians, a medical opinion is only as good as the medical history upon which it is based. Where medical opinions are based on inaccurate medical histories, we find them unpersuasive and give them little weight. Somers v. SAIF, 77 Or App 259 (1986); Miller v. Granite Construction Co., 28 Or App 470 (1977).

Here, claimant was less than candid with his treating physicians. Just as he had with Dr. Grant in his previous case, claimant in this case withheld significant information from Dr. Webb and Dr. Campagna regarding his water skiing and weight lifting activities, information which may have changed their opinion as to the cause of his back condition. In light of these inaccurate histories, we find Dr. Webb's and Dr. Campagna's opinions unpersuasive and, therefore, insufficient to establish medical causation. Accordingly, we conclude that claimant has failed to establish that his work activities were the major contributing cause of his current back condition and need for surgery.

ORDER

The Referee's order dated May 23, 1991 is reversed in part and affirmed in part. The SAIF Corporation's denial is reversed and upheld. The Referee's $2,000 attorney fee award is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DARREN L. MINTO, Claimant
WCB Case No. TP 91014
THIRD PARTY DISTRIBUTION ORDER
Thon & Beck, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Aetna Casualty & Surety Company, as 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, Aetna seeks distribution in accordance with ORS 656.593(3) of the proceeds of a settlement arising out of a third party medical malpractice action brought in California. Claimant contends that Aetna's lien is invalid because California law prohibits enforcement of workers' compensation liens on medical malpractice recoveries. Moreover, claimant argues that Aetna should be estopped from enforcing its lien. We conclude that Aetna is entitled to a portion of its asserted lien.

FINDINGS OF FACT

Claimant sustained a compensable right shoulder injury on November 25, 1985, while working for Aetna's insured. His claim was closed by Determination Order dated November 24, 1986, which awarded him temporary disability compensation through March 16, 1986, but no permanent disability benefits.

Thereafter, claimant moved to California and began treating with Dr. Snell, M.D. On February 17, 1987, Dr. Snell performed a surgical resection of claimant's distal clavicle and acromioclavicular joint. It is this surgery which formed the basis for claimant's subsequent third party medical malpractice action. The total cost of that surgery, including hospital expenses, was $4,733.10.

Following surgery, claimant was dissatisfied with the results of Dr. Snell's surgery. He consulted Dr. Bingham. In May 1987, Dr. Bingham performed a second surgery to repair the coracoclavicular ligament. This reconstructive surgery would not have been necessary but for Dr. Snell's surgery.

A second Determination Order issued on December 7, 1987, which awarded claimant 25 percent unscheduled permanent disability, as well as temporary disability commencing on the date of Dr. Snell's surgery and continuing through October 13, 1987.

In June 1988, claimant, through California counsel, filed a medical malpractice suit in California. The suit alleged that Dr. Snell had negligently provided treatment of his right shoulder condition. In particular, the complaint alleged that Dr. Snell's February 17, 1987 surgery was "negligent and not necessary in the first place."

In October 1988, Aetna's counsel and counsel for Dr. Snell's medical malpractice insurer spoke on the telephone. This conversation was memorialized by an October 13, 1988 letter wherein Aetna's counsel notified Dr. Snell's counsel that Aetna asserted a third party lien against any eventual recovery from the third party action. Aetna's counsel further noted that any eventual settlement of the third party action required Aetna's approval. Also on October 13, 1988, Aetna's counsel sent a letter to claimant's California counsel informing him of Aetna's asserted lien and the need for Aetna's involvement in the distribution of any third party settlement or judgment proceeds.

Claimant's California counsel responded by letter dated October 19, 1988, wherein he acknowledged that Aetna asserted a lien on any eventual third party

recovery and indicated that he would contact Aetna "if and when we get to the point of discussing settlement." The letter also indicated some question on counsel's behalf as to whether Aetna's lien would be valid under California law.

By letter dated March 3, 1989, claimant's counsel informed counsel for Aetna that Dr. Snell had died in a traffic accident and that the third party action would proceed against Dr. Snell's estate.

Claimant's counsel again raised a question regarding the validity of Aetna's asserted lien in a May 19, 1989 letter to Aetna's counsel. Claimant's counsel solicited "some convincing legal authority for [Aetna's] position." Alternatively, claimant's counsel disputed Aetna's entitlement to "full reimbursement" arguing, in effect, that Aetna's lien could not validly include expenses incurred as a result of the original compensable injury, but rather could only include those costs which were due to the medical negligence of Dr. Snell. Finally, claimant's counsel requested that the paying agency provide him with its "bottom line" figure to satisfy its lien for purposes of negotiating a settlement with Dr. Snell's estate.

By letter dated July 11, 1989, Aetna's counsel filed a Notice of Lien with the California court before which the third party action was pending. Copies of the lien notice were sent to counsel for claimant and Dr. Snell.

One week later, on July 18, 1989, counsel for Dr. Snell "advised" Aetna's counsel by letter that Aetna's lien was precluded under California law. Dr. Snell's counsel accompanied the letter with copies of the section of the California statutes and a California case relied upon in reaching that conclusion.

Following claimant's completion of a vocational training program, a third Determination Order issued on July 27, 1989, awarding claimant 30 degrees scheduled permanent disability for loss of use of the right forearm (wrist).

On August 3, 1989, claimant's counsel wrote to Aetna's counsel indicating that he was awaiting a response from Dr. Snell's counsel to an earlier demand letter. Claimant's counsel advised that he had informed the third party defendant of Aetna's lien in the approximate amount of $37,000. He further advised Aetna's counsel that a follow-up letter had been sent that day to alert the third party defendant that Aetna's lien might be greater than originally anticipated.

On August 25, 1989, claimant's counsel asserted by letter that Aetna's lien was unenforceable under California law and, therefore, that Aetna's lien would not be considered in the third party action.

Approximately one year later, in August 1990, the third party action was settled for the sum of $100,000. Aetna's approval was not requested prior to the settlement. Aetna's counsel subsequently received notice of the settlement in the form of a copy of claimant's Request for Dismissal with Prejudice of the third party suit.

The settlement proceeds were distributed in the following manner. Claimant's attorney received $33,333.33 in fees and $7,776.74 in litigation expenses. Claimant received the remaining $58,889.93.

By letter dated November 29, 1990, Aetna's counsel advised claimant's counsel of its intent to "maintain and rely" upon its lien. Aetna's counsel requested copies of the settlement documents. Claimant's counsel responded by letter dated December 21, 1990, indicating that Aetna's lien was unenforceable under California law and that the settlement proceeds had been disbursed.

On January 22, 1991, Aetna's counsel sent a letter to Dr. Snell's counsel, again asserting entitlement to a lien, and including a copy of Allen v. American Hardwoods, 102 Or App 562, rev den 310 Or 547 (1990), which, Aetna asserted, supported its assertion of a lien on the proceeds of the third party settlement. A copy of that letter was sent to claimant's attorney.

Aetna asserts entitlement to a lien of $40,375.63, excluding future costs.

ULTIMATE FINDINGS OF FACT

The costs of Dr. Snell's February 17, 1987 surgery, totalling $4,733.10, and temporary disability paid from that date until the date of Dr. Bingham's May 1987 surgery, were due to the compensable injury and were not additional expenses incurred as a result of the alleged malpractice.

The costs of Dr. Bingham's May 1987 surgery and subsequent disability benefits paid after that surgery date were additional expenses incurred as a result of the alleged malpractice.

A distribution of third party settlement proceeds in which Aetna receives that portion of its $40,375.63 asserted lien remaining when the cost of Dr. Snell's February 17, 1987 surgery ($4,733.10) and temporary disability benefits paid from Dr. Snell's surgery until the date of Dr. Bingham's May 1987 surgery are deducted, would be "just and proper."

CONCLUSIONS OF LAW AND OPINION

Under Oregon law, a paying agency is entitled to recovery of its claim costs from a third party settlement for medical malpractice to the extent that the agency is receiving reimbursement for additional expenses incurred as a result of the malpractice. Ray Littlefield, 41 Van Natta 1781 (1989); John Galanopolous, 43 Van Natta 615, 626 (1982). The burden of proof is upon the paying agency to establish the extent of the expenditures attributable to the malpractice. Id.

However, before we consider the particulars of Aetna's lien, we must first address claimant's threshold argument that, pursuant to applicable California law, Aetna is not entitled to a lien upon the third party recovery. We do not agree with claimant's contention.

We conclude, as contended by Aetna, that this case is controlled by the Court of Appeals' decision in Allen v. American Hardwoods, 102 Or App 562, rev den 310 Or 547 (1990). In Allen, two claimants, during the course of their employment for an Oregon employer, were involved in a motor vehicle accident that occurred in Michigan. SAIF, as the insurer for the Oregon employer, accepted the claims and provided benefits. The claimants subsequently commenced legal actions against two third-party defendants in the Michigan courts. Both claims were eventually settled. SAIF asserted a paying agency lien against the third-party recoveries. The claimants contended that Michigan law, pursuant to which a paying agency is not entitled to reimbursement for the type of expenses that SAIF paid, should be applied.

The Board disagreed. We concluded that, while claimant's right of tort recovery against the third parties was determined by Michigan law, SAIF's right to share in the settlement proceeds was governed by Oregon law. On appeal, the court affirmed. The court relied upon the Restatement (Second) Conflict of Laws, sec. 185, which provides:

> "The local law of the state under whose workman's compensation statute an employee has received an award for an injury determines what interest the person who paid the award has in any recovery for tort or wrongful death that the employee may obtain against a third person on account of the same injury."

The court noted that the Restatement is in accord with Larson. See 4 Larson, Workmen's Compensation Law, 16-171, sec. 88.00 (1989). Moreover, the court reasoned that Oregon has a vital interest in applying its law to determine the interest of an Oregon workers' compensation carrier in settlement proceeds that are obtained by Oregon workers. Allen, 102 Or App at 567.

We conclude that the same analysis applies here. Claimant asserts that, under California law, a workers' compensation lien is not available in a medical malpractice action. However, in accordance with the court's reasoning in Allen, supra, Oregon law governs the validity of Aetna's lien on the California third party recovery. Under Oregon law, no provision exists which precludes Aetna from recovery of its lien from the proceeds of a medical malpractice action. Cf. Toole v. EBI Companies, 108 Or App 57 (1991) (paying agency lien does not extend to settlement proceeds resulting from legal malpractice in pursuit of third party claim).

Claimant next contends that Aetna should be estopped from recovery of its lien. Claimant notes Aetna's failure to register any objection upon its receipt of the July 18, 1989 letter from Dr. Snell's counsel and the August 25, 1989 letter from claimant's counsel, wherein Aetna was advised of California case law and a statute which, it was argued, precluded workers' compensation liens on medical malpractice actions. Claimant contends that he reasonably interpreted Aetna's silence as acquiescence to claimant's legal position and, therefore, that the third party action was settled based upon the assumption that Aetna had abandoned its lien.

We do not agree with claimant's contention that, under the circumstances here, Aetna's lack of affirmative response to the letters in question precludes Aetna from asserting its paying agency lien. We first note that, shortly prior to both letters, Aetna had filed a Notice of Lien with the California court, with copies to counsel for claimant and Dr. Snell. Therefore, Aetna had taken steps to "perfect" its lien regardless of the legal positions of counsel for claimant and Dr. Snell's estate. This Notice of Lien was never withdrawn. In addition, on August 3, 1989, subsequent to the July 18, 1989 letter to Aetna from Dr. Snell's counsel, Aetna received a letter from claimant's counsel which continued to acknowledge Aetna's lien. Therefore, as of that time, Aetna had no reason to believe that claimant challenged its entitlement to a lien.

Having concluded that Aetna may recover its lien out of the medical malpractice action, we determine a "just and proper" distribution of the third party settlement. 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). Finding no persuasive reason to depart from our general approach of distributing third party settlement proceeds in accordance with ORS 656.593(1), we proceed with our analysis.

Pursuant to ORS 656.593(1)(a), cost and attorney fees 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. See 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. Following the aforementioned distribution of a third party recovery, any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

As previously noted, Aetna is entitled to recovery of its claim costs to the extent that it is receiving reimbursement for additional expenses incurred as a result of the medical malpractice. Ray Littlefield, supra. By affidavit, Aetna asserts entitlement to a lien of $40,375.63, not including future expenditures. (Ex. J).

Aetna argues that it is entitled to recovery of the costs of Dr. Bingham's reconstructive surgery, including resulting disability. We agree. Aetna has established that claimant would not have required the reconstructive surgery absent Dr. Snell's prior surgery. Therefore, Aetna is entitled to recovery of those costs.

Aetna also argues that it is entitled to recovery of its costs directly related to Dr. Snell's surgical procedure. Relying upon the allegation contained in claimant's third party complaint, Aetna argues that the surgery performed by Dr. Snell was not only negligently performed, but unnecessary. Therefore, Aetna asserts, costs related to that surgery, including the cost of the procedure itself, are recoverable. We do not agree.

Settlement of the third party action does not amount to a concession that the surgery was, in fact, unnecessary. Moreover, there is no contention that the surgery was not related to claimant's compensable condition. Under such circumstances, we conclude that Aetna has failed to establish that Dr. Snell's surgery was "an additional expense incurred as a result of the malpractice." Littlefield, supra. Consequently, Aetna may not receive reimbursement for the costs of that surgery or for temporary disability benefits incurred between that surgery and Dr. Bingham's subsequent surgery. Littlefield, supra; Galanopolous, supra, Accordingly, Aetna's $40,375.63 asserted lien will be reduced by the $4,733.10 costs associated with Dr. Snell's surgery and the temporary disability benefits paid between Dr. Snell's February 17, 1987 surgery and Dr. Bingham's May 1987 surgery.

Based on the aforementioned reasoning, we conclude that the third party settlement proceeds should have been distributed in the following manner:

Settlement	$100,000.00
Attorney Fee (1/3)	- 33,333.33
Litigation costs	- 7,776.74
Sub-total	$ 58,889.93
Claimant's 1/3 share	- 19,629.98
Remaining balance	$ 39,259.95

As previously discussed, the cost of Dr. Snell's surgery ($4,733.10) plus temporary disability benefits paid between Dr. Snell's February 17, 1987 surgery and Dr. Bingham's May 1987 surgery are not reimbursable. Therefore, Aetna's $40,375.63 asserted lien will be reduced by the aforementioned expenses. Because such a reduction will place Aetna's reimbursable lien at an amount beneath the $39,259.95 remaining balance of proceeds from the third party settlement, claimant will be entitled to the balance remaining after distribution of Aetna's share. See ORS 656.593(1)(d).

Accordingly, since the proceeds of the third party settlement have already been disbursed, claimant is directed to reimburse Aetna in the amount described above.

IT IS SO ORDERED.

February 28, 1992 Cite as 44 Van Natta 358 (1992)

In the Matter of the Compensation of
RODNEY T. BUCKALLEW, Claimant
WCB Case No. 90-06594
ORDER ON REVIEW
Donald Hooten, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

The self-insured employer requests review of those portions of Referee McGeorge's order that: (1) denied its motion to dismiss claimant's hearing request for lack of jurisdiction; and (2) set aside its de facto denial, as modified by the June 26, 1990 written partial denial, of claimant's occupational disease claim for a left lower leg condition. Claimant cross-requests review of that portion of the Referee's order which awarded his counsel $2,500 for services at hearing. On review, the issues are jurisdiction, compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact," with the following modification.

The Referee found that "[c]laimant's work activities were the material contributing cause of his left lower extremity condition" and that "[t]he repetitive microtrauma due to the amount of walking involved in claimant's job was a material contributing cause of the Charcot joint." (O&O at p. 4).

Instead, we find that repetitive microtrauma due to walking at work was the major contributing cause of claimant's Charcot's joint condition.

CONCLUSIONS OF LAW AND OPINION

Applicable law

Claimant's hearing request was filed before May 1, 1990, and the hearing convened before July 1, 1990. Therefore, the case is properly analyzed under the law in effect prior to the July 1990 amendments. See Or Laws 1990 (Special Session), ch.2, 54(2); Brad R. Christie, 43 Van Natta 608 (1991).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The employer contends that the Referee had no jurisdiction to decide the compensability of claimant's Charcot's disease because the March 22, 1990 request for hearing was premature with respect to that condition, and because it had insufficient notice of hearing once the issue was properly raised.

In Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), the claimant requested a hearing on the compensability of his condition before the full sixty days to process the claim had expired. The court held:

> "The statutory scheme does not reasonably permit a hearing on compensability of the claim prior to a timely acceptance or denial or prior to the expiration of the time in which the carrier may investigate and consider the claim without risking penalties. Until one of those events occurs, it is not known whether a hearing will be necessary or, if so, what issue or issues will be presented at the hearing."

In this case, the employer had oral notice of a claim for a pulled leg muscle on or about November 19, 1989 (Ex. 7). On December 8, 1989, claimant filed a claim form for a "ruptured muscle - swelling" in the left "lower leg" (Ex. 7). On January 18, 1990, Robert Manley, M.D., noted in his chart, "In looking over the tests that came back, it is a concern that [claimant] probably has a neuropathic joint." This is the condition that was ultimately diagnosed as Charcot's joint disease in the left ankle. The employer received this report on January 25, 1990. It was the first notice that the employer received regarding this condition. The statutes in effect at that time allowed the employer sixty days, or until March 26, 1990, to process the claim. See former ORS 656.262(6). Claimant filed a request for hearing on the issues of entitlement to temporary total disability (TTD) and penalty and attorney fee on March 22, 1990. He did not request a hearing on compensability at that time, and since temporary total disability benefits had not been paid within 14 days, the request for hearing which he did file was not premature.

The employer finally denied the Charcot's joint claim on June 26, 1990. Claimant supplemented his request for hearing to include the Charcot's joint denial at the TTD hearing on June 29, 1990. Therefore, we conclude that claimant's hearing request was not premature.

Surprise

The employer nevertheless contends that the matter still should not have been heard because of the requirement in ORS 656.283(5) that "[a]t least 10 days' prior notice of the time and place of hearing shall be given to all parties in interest by mail." The purpose of this statute is to insure that all parties receive advance notice of the hearing so that they can attend and have a reasonable opportunity to respond to the issues and make a proper record to protect their interests, as well as advance their own positions.

The particular facts of this case show that the employer received a hearing that achieved substantial justice and fulfilled the purpose of ORS 656.283(5). The employer had notice of this claim since January 25, 1990, some six months before the hearing (Ex. 9-2). On January 30, 1990, the employer began actively investigating the relationship of the Charcot's joint disease to claimant's work activity and obtained expert medical opinions from Dr. Manley, Dr. Youker and Dr. Bergstrom (Ex. 32, App. Brief at p. 2). The employer retained legal counsel on March 30, 1990 after receipt of the March 22, 1990 request for hearing regarding payment of temporary disability benefits (Ex. 32). On April 3, 1990, the employer received notice of the hearing and the employer's legal counsel became actively involved in the investigation of the claim (Ex. 32). By June 8, 1990, the employer determined that it had obtained sufficient evidence to deny the Charcot's disease portion of the claim. The denial letter was mailed on June 26, 1990 (Ex. 32). Legal counsel for the employer attended the hearing on June 29, 1990 where claimant amended the issues for hearing by challenging the June 26, 1990 denial. The Referee granted the employer's motion for a continuance and the record was held open for admission of testimony by Dr. Manley, Dr. Bergstrom and Dr. Youker regarding the Charcot's disease claim (Exs. 29, 30 and 31).

The above indicates that the employer had an active and meaningful opportunity to participate in the hearing regarding the Charcot's disease claim. Any surprise resulting from the issue being raised at hearing was remedied by the continuance granted by the Referee pursuant to OAR 438-06-031 and 438-06-091(3). The employer does not contend that it was prevented from discovering or presenting evidence. It points to no other action it would have taken on the claim in the event its motion to dismiss had been granted and claimant had filed a new hearing request. For these reasons, we conclude that any surprise caused by the raising of the compensability issue at hearing was remedied by the continuance granted by the Referee. See OAR 438-06-031 and 438-06-091(3); Glory Yankauskas, 43 Van Natta 670 (1991) (Had the party required additional time to prepare for the issue, she could have requested a continuance); Mary L. Potter, 43 Van Natta 300, 301 (1991). Therefore, we conclude that the employer was not deprived of a fair hearing due to the Referee's exercise of jurisdiction over the issues presented. We further conclude that the Referee's granting of a continuance and denial of the employer's motion to dismiss on a due process basis were within her discretion, allowed the employer sufficient opportunity to prepare and present its case and served the interests of substantial justice. See ORS 656.283(7); William E. Sanders, 43 Van Natta 558, 559 (1991). Consequently, claimant properly invoked the Referee's jurisdiction and the employer was not deprived of a fair hearing due to the Referee's exercise of that jurisdiction.

Compensability

Claimant's work involved a great deal of walking and he claims that his current left lower leg condition is due to his work activities over time. Therefore, we conclude that his claim is for an occupational disease resulting from a "series of traumatic events or occurrences" under former ORS 656.802(1)(c). To establish that his condition is compensable under subsection (1)(c), claimant must prove that these traumatic events at work were the major contributing cause of his left lower leg condition. Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). "Major cause" means an activity or exposure or combination of activities or exposures which contributes more to the causation or worsening than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); David K. Boyer, 43 Van Natta 561 (1991). However, for the purpose of determining whether a worker has met the major contributing cause standard, we do not consider his susceptibility or predisposition to the disease. Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991).

A predisposition is a condition of special susceptibility to a disease, not a disease itself. Preston v. Wonder Bread, 96 Or App 613, rev den 308 Or 405 (1989) ("All causes of a disease, as opposed merely to a susceptibility or predisposition, must be considered in determining which, if any, was the major contributing cause.") (Emphasis in original); see also David K. Boyer, supra at 564, n.2 ("[T]he situation in which factors peculiar to an individual cause a disease is quite different from that in which an individual is susceptible to development of a disease.") (Emphasis in original).

In the present case, the Referee found, and we agree: "Claimant's diabetic neuropathy created a predisposition to development of Charcot's joint, but did not cause the condition." (O&O at p. 4; see Exs. 29-27, 30-9). Therefore, as required under Spurgeon, we do not consider claimant's diabetes or his diabetes-related neuropathy in determining whether he has carried his burden of proof concerning the causation of his Charcot's joint condition.

It is undisputed that claimant's work activities involved a great deal of walking and that the repetitive trauma associated with walking at work contributed to the development of his Charcot's joint. The question is whether

claimant's work exposure was the major contributing cause of the condition. We conclude that it was.

Dr. Youker, treating endocrinologist, explained the etiology of Charcot's joint as follows:

> "A Charcot's joint appears to be a joint secondary to mechanical trauma to that joint. Now, it appears that the way this joint develops is there is loss of position sense known as proprioception. That allows for trauma to that joint that would otherwise not occur because we have the sense of where those joints are and we don't traumatize them. If you lose the sense of where those joints are, you can easily traumatize those joints, and then you develop the secondary trauma, arthritis, poor fitting joints that you would define as Charcot's joint." (Ex. 29-9).

Dr. Youker also stated, "[Y]ou have to have trauma in order to develop the Charcot's joint. And I think that walking is enough trauma for someone who lacks the sensory perception in their foot." (Ex. 29-11). Dr. Youker opined that, as between the claimant's nerve damage secondary to his diabetes and his walking at work, one was not "more causative than the other." (Exs. 29-14, 29-15). Taken out of context, we find the aforementioned conclusion to be misleading. The issue was not framed for the doctors in terms of susceptibility versus cause; had it been so framed, we are persuaded by the evidence they did offer that they saw the diabetes and neuropathy as predispositions and not causes. For example, the following interchange, in contrast, persuades us that Dr. Youker intended to distinguish between claimant's diabetes-related predisposition to developing Charcot's joint and the causation of that condition:

> Question (by Counsel): "And that as far as the diabetic neuropathy and microtrauma or repeated trauma, you can't assess which would be more responsible for the development of the condition?
>
> Answer (by Dr. Youker): "Well, I guess, to be honest with you, what causes the condition is the repeated trauma. I mean, the repeated trauma is what causes the Charcot's joint." (Ex. 29-21)

Dr. Manley, treating orthopedist, described the Charcot's process as microfractures within the bone and destruction of articular cartilage. (Ex. 30-21). Counsel asked Dr. Manley, "Does the diabetes cause the microfractures and the destruction of the cartilage or is that a response to an outside force?" Dr. Manley responded, "That's a response to an outside force." (Ex. 30-22). Based on the medical evidence, we conclude that Dr. Manley, like Dr. Youker, distinguished between claimant's diabetes-related neuropathy and the actual work-related causation of the Charcot's joint.

Dr. Bergstrom, internist, examined claimant on behalf of the employer. He described the neuropathy and microtrauma as "two prerequisites" and "two conditions" which led to the Charcot's joint. (Ex. 31-5). He was unable to state, as between claimant's neuropathy and his work activity, which of the two was "more responsible" for the Charcot's joint. (Exs. 30-10 and 30-11). However, when asked to describe the "causal element" in the joint remodeling process involved in the development of Charcot's joint, Dr. Bergstrom stated, "Probably the causal element of that is in terms of that there are new stresses or there's the trauma or there is changes that are placed upon the -- that joint leading to instability[.]" (Ex. 31-18).

In light of the consistency among the medical opinions regarding work causation, the experts' reasoning supporting a work connection, and particularly

considering the well reasoned explanations provided by Dr. Youker and Dr. Manley, we conclude that claimant has carried his burden of proving that his work activities were the major contributing cause of his Charcot's joint.

Attorney fees

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that an award of $5,800 for services concerning employer's denial is a reasonable amount for claimant's counsel's services rendered at hearing. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, the value of the interest involved, as well as the statement of services provided by counsel.

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. 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 attorney's services on review concerning the compensability issue is $1,200, 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 August 6, 1990 is affirmed with the exception that claimant is entitled to an attorney fee of $5,800 for services at hearing to be paid directly to claimant's attorney by the self-insured employer. For services on review, claimant is awarded an assessed attorney fee of $1,200, to be paid directly to claimant's attorney by the self-insured employer.

February 28, 1992 Cite as 44 Van Natta 362 (1992)

In the Matter of the Compensation of
EDWARD B. CASTRO, Claimant
WCB Case No. 90-15002
ORDER ON REVIEW
Paul S. Bovarnick, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Emerson's order which set aside a Determination Order that: (1) awarded claimant temporary total disability benefits from December 1, 1989 through January 10, 1990; (2) awarded claimant temporary partial disability benefits from January 11, 1990 through June 8, 1990; and (3) found that claimant was medically stationary on June 8, 1990. Claimant cross-requests review of that portion of the Referee's order which declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable refusal to pay temporary total disability benefits and to provide documents. On review, the issues are premature closure, extent of temporary disability, and penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee, applying the 1990 amendments to the workers' compensation statutes, concluded that the claim was prematurely closed. The insurer objects to this conclusion, contending that the medical evidence supports the Determination Order finding that claimant was medically stationary on June 8, 1990.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to show that he was not medically stationary as of the date the Determination Order issued. Berliner v. Weyerhaeuser Co., 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question which must be resolved based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985).

We agree with claimant that he carried his burden of proof. Dr. Frankel, D.C., claimant's then-treating chiropractor, merely anticipated a medically stationary date of May 30, 1990. (Ex 6). Such evidence is not proof that claimant actually was medically stationary on that date. See Lloyd Fisher, 41 Van Natta 1694 (1989). Moreover, as of January 11, 1990, Frankel estimated that claimant would require three to four months of further treatment. (Ex. 6). There is no evidence that claimant received any treatment after he was incarcerated in late January 1990. Frankel also anticipated that treatment would resume following claimant's release from prison. (Ex. 9).

Because claimant proved that he was not medically stationary on June 8, 1990, and did not become medically stationary prior to the Determination Order, we agree with the Referee that the July 2, 1990 Determination Order prematurely closed the claim.

Extent of Temporary Disability

The insurer next argues that the Determination Order correctly awarded claimant temporary total disability from December 1, 1989 through January 10, 1990 because, on January 11, 1990, Dr. Frankel released claimant for modified work. We disagree.

ORS 656.268(3) requires that payment of temporary total disability benefits continue until any of the specified events occurs. Among such events is a written release to return to modified employment by the attending physician, and "such employment is offered in writing to the worker and the worker fails to begin such employment." ORS 656.268(3)(c). Although there is evidence that Dr. Frankel released claimant for modified work on January 11, 1990, there is no evidence that Dr. Frankel gave claimant a written release or that modified employment was offered to claimant in writing. ORS 656.268(3)(c), therefore, is not satisfied and the insurer was not entitled to discontinue temporary total disability payments on January 10, 1990.

Section 50 of Senate Bill 1197, however, provides:

> "Notwithstanding any other provision of this chapter, an injured worker is not eligible to receive compensation under ORS 656.210 or 656.212 [which provide for temporary total and partial disability benefits] for periods of time during which the worker is incarcerated for the commission of a crime. As used in this section, an individual is not 'incarcerated' if the individual is on parole or work release status."

Based on section 50, the Referee determined that claimant's temporary disability benefits were suspended. The Referee concluded, however, that claimant's entitlement to such benefits ended on May 7, 1990, the date that the new Act was approved by the Governor.

This case is subject to the law as amended by 1990 Oregon Laws, chapter 2. Section 50 is not an exception to the Act's general applicability provision. 54(3). We further find that application of the new law will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Ida M. Walker, 43 Van Natta 1402 (1991). The provision therefore applies retroactively to claimant's case rather than on the date of the Governor's approval.

Claimant asserts that he does not fall under section 50 because he was not incarcerated "for the commission of a crime." Rather, claimant contends that the evidence only shows that he was "incarcerated after being accused of violating his parole" and that he was released when "that accusation was found to be untrue." (Resp. Brief at 2).

As stated above, section 50 provides that temporary disability benefits are not available to persons who are "incarcerated for the commission of a crime." We construe this provision in light of OAR 436-60-045. That rule provides that a worker is "incarcerated for commission of a crime" when in pretrial detention or imprisoned following conviction of a crime.

In regard to parole, upon being informed and having reasonable grounds to believe that a person has violated the conditions of parole, the Board of Parole and Department of Corrections may order the arrest and detention of such person. ORS 144.331, 144.350. ORS 144.345 authorizes the revocation of parole for any person who violates the conditions of parole. After conducting a hearing and finding that the conditions of parole have been violated, the State Board may "reinstate or continue the alleged parole violator on parole subject to the same or modified conditions of parole or revoke parole and require that the parole violator serve a term of imprisonment as provided by ORS 144.346." ORS 144.343(6).

In this case, the record reveals that claimant was incarcerated for a "parole violation." (Tr. at 8). Although he contends that he was released upon a finding that he did not violate the conditions of parole, we conclude that he was "incarcerated for the commission of a crime" under section 50 of the new law. As provided by OAR 436-60-045, a person is "incarcerated" whether it is pretrial detention or following conviction of a crime. Therefore, it is immaterial whether claimant was detained on suspicion of violating the conditions of parole, based on ORS 144.350, or he actually was found to have engaged in such conduct and was incarcerated, based on ORS 144.343(6). Claimant therefore is disqualified from receiving temporary disability benefits during the period of incarceration.

In conclusion, we find that claimant is entitled to temporary disability from December 1, 1989 to the day before his January 1990 incarceration. Moreover, because we have found that the claim was prematurely closed, claimant is entitled to temporary disability benefits from the day after his July 1990 release from incarceration until such benefits may be terminated in accordance with law.

Penalties and Attorney Fees

Claimant contends that he is entitled to a penalty and attorney fee based on the insurer's termination of temporary disability benefits, see ORS

656.262(10), and delay in providing a requested document, see id.; OAR 438-07-015(2). Such actions, if unreasonable, warrant a penalty based on the "amounts then due" or the assessment of attorney fees under ORS 656.382(1). See ORS 656.262(10); Nicolasa Martinez, 43 Van Natta 1638 (1991).

In this case, there was no unreasonable delay or refusal to pay temporary disability benefits. To the contrary, claimant was paid temporary disability until June 8, 1990, although he was only entitled to such benefits from December 1, 1989 through January 1990. Since the insurer's termination of benefits was justified, claimant is not entitled to a penalty under ORS 656.262(10). Moreover, the insurer has not unreasonably resisted the payment of compensation. Therefore, claimant is not entitled to attorney fees under ORS 656.382(1). Aetna Casualty Company v. Jackson, 108 Or App 253 (1991).

ORDER

The Referee's order dated March 15, 1991 is affirmed in part and modified in part. That portion of the Referee's order that found that claimant was entitled to temporary disability benefits from December 1, 1989 through May 7, 1990 is modified. Claimant is entitled to such benefits from December 1, 1989 to the day before his January 1990 incarceration. Claimant is also entitled to temporary disability benefits from the day after his release from incarceration until such benefits can be terminated in accordance with law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fee payable from this order and the Referee's order shall not exceed $3,800. The remainder of the order is affirmed.

February 28, 1992 Cite as 44 Van Natta 365 (1992)

In the Matter of the Compensation of
ROY L. CENTER, Claimant
WCB Case Nos. 90-11778 & 90-07169
ORDER ON REVIEW
Babin & Keusink, Claimant Attorneys
Norman F. Kelley, Assistant Attorney General
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Michael V. Johnson's order which dismissed claimant's hearing request for lack of jurisdiction. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. In the first paragraph of the Referee's findings, the reference to Crescent City, Oregon should be Crescent City, California.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee found that claimant was not an Oregon subject worker and concluded that he did not have jurisdiction over this matter because claimant was not an Oregon worker. The Referee therefore dismissed claimant's hearing request. We do not agree that the Referee did not have jurisdiction.

The Board has jurisdiction over 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); 656.283(1). This matter concerns whether claimant is an Oregon subject worker. Consequently, this is a matter concerning a claim over which we have jurisdiction, because it is a matter in which a worker's right to receive compensation is directly at issue.

We note that no party requested that claimant's request for hearing be dismissed. We are aware of no other authority supporting a dismissal, absent such a request. Accordingly, because no party requested the dismissal, because we have concluded that we have jurisdiction over this matter, and because we find the record sufficiently developed, we reinstate the hearing request and proceed to the merits.

On February 4, 1990 Rick Bentley, an independent contractor, came to claimant's house in Brookings, Oregon, and asked claimant and claimant's brother to work on a roofing job in Crescent City, California. Claimant and his brother agreed to do the work for six dollars an hour, not to exceed 50 dollars a day. Bentley drove claimant and claimant's brother to the job site in Crescent City. Bentley sometimes performed subcontractor work in Oregon for Horton Brothers (hereafter Horton), a general contractor. On February 4, 1990, Bentley took a tar pot from Horton, without obtaining authorization to do so. Claimant had previously performed two jobs for Bentley in Oregon on a job-by-job basis, before the Crescent City job. (Tr. 68). While performing the Crescent City job, claimant was injured when the handle of the bucket of hot tar he was carrying broke, and tar spilled onto his leg and hands.

Claimant filed a workers' compensation claim against Horton Brothers in the belief that Horton was the general contractor of the project claimant was working on at the time he was injured. Claimant also filed a claim against Rick Bentley Construction.

At the outset, we note that there is no evidence that claimant was either an employee of Horton when he was injured or that Rick Bentley was a subcontractor of Horton Brothers at the time of claimant's injury. Michelle Horton-Tidwell, president of Horton, testified that claimant was not employed by Horton on the date of the injury and that she did not believe he had ever been employed by Horton. Horton-Tidwell further testified that Bentley was not an employee or a subcontractor for Horton at the time of claimant's injury. Moreover, Bentley made a sworn statement that the Crescent City job was not related to any work being done by Horton and that he took the tar pot from Horton without permission. Claimant testified he filed a claim against Horton because he was unsure whether a subcontractor relationship existed. Claimant told a Department of Insurance and Finance investigator that he knew Bentley had worked as a subcontractor for Horton in the past, but was not working as a subcontractor on the Crescent city job. Claimant's testimony at the hearing was consistent with his statements to the DIF investigator. Based on this evidence, we conclude that Bentley was not Horton's subcontractor at the time of claimant's injury.

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of Oregon incidental to the Oregon employment. ORS 656.126(1). Mere residence in Oregon is insufficient to make a worker an Oregon employee for the purposes of the Workers' Compensation Law. Hollingsworth v. May Trucking, 59 Or App 531, 535 (1982).

In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." Under this test, the key inquiry is the "extent to

which claimant's work outside the state was temporary." Power Master Inc. v. Blanchard, 103 Or 467 (1990) citing Phelan v. H.S.C. Logging, Inc., 84 Or App 632 (1988); Hobson v. Ore Dressing, Inc., 87 Or App 397, 400, rev den 304 Or 437 (1987).

The Board has previously held that out-of-state work must be incidental to work performed in Oregon for an Oregon employer and there must be proof of "an established employment relationship between [the worker] and this employer in Oregon before the out of state injury occurs." Steven A. Dancer, 40 Van Natta 1750 (1988), citing Daryl W. Hugulet, 37 Van Natta 1518, 1520 (1985).

Here, claimant did not have an Oregon job to return to after the Crescent City job was finished. Although claimant might have anticipated doing more jobs for Bentley in Oregon, on a job-by-job basis, he could not have had a reasonable expectation of returning to work for Bentley in Oregon after the roofing job in California was finished. Therefore, claimant's work in California was not "incidental" to employment in Oregon. See Lyle E. Estes, 43 Van Natta 62 (1991).

Claimant has not proven that he was employed in Oregon by Bentley. Therefore, claimant's work temporarily in California was not "incidental" to Oregon employment for Bentley. Consequently, we conclude that claimant was not a subject worker in Oregon when he was injured in California.

Because we conclude that claimant's employment is not incidental to Oregon employment for Rick Bentley Construction, we do not address the Department of Insurance and Finance's argument that claimant's employment in California was casual under ORS 656.027(3).

ORDER

The Referee's order dated April 10, 1991 is reversed. Claimant's request for hearing is reinstated. The SAIF Corporation's denials on behalf of the Department of Insurance and Finance and on behalf of Horton Brothers are upheld.

February 28, 1992 Cite as 44 Van Natta 367 (1992)

In the Matter of the Compensation of
CAROL M. COTE-WILLIAMS, Claimant
WCB Case No. 90-20819
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Podnar's order that declined to direct the insurer to pay several unpaid bills from claimant's chiropractor. In its respondent's brief, the insurer contends that the Referee erred in: (1) addressing this medical treatment issue; (2) awarding an attorney fee under ORS 656.382(1); and (3) admitting Exhibit 7 (a check-the-box letter signed by claimant's chiropractor concerning the chiropractor's bills and the insurer's payments) as a medical report. We vacate in part and reverse in part.

At issue here is the compensability of claimant's chiropractic care. The Referee declined to order the insurer to pay for claimant's chiropractic care after July 1990, but awarded an assessed attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable failure to pay for claimant's July 1990 chiropractic care within 60 days. On review, claimant challenges the Referee's

refusal to order the insurer to pay for additional chiropractic treatment in August and September 1990. The insurer argues in response that the Referee lacked jurisdiction under ORS 656.704 and 656.327 to hear this medical services dispute. We find the insurer's argument persuasive and vacate the Referee's order as to the medical services issue for lack of jurisdiction.

Following her compensable injury on October 14, 1989, claimant began treating with a chiropractor, who was her attending physician. On July 12, 1990, the insurer notified claimant that those treatments would not be paid for after July 1, 1990 because, due to changes in the law, her chiropractor could no longer act as her attending physician and authorize her palliative chiropractic care. (See Ex. 1). Claimant continued to treat with her chiropractor on July 23, August 6 and 21, and September 4 and 7, 1990. (Tr. 6-7). When the insurer failed to pay the chiropractor bills, claimant filed a request for hearing on November 8, 1990.

Because claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990, the Referee applied the law as amended by Oregon Laws 1990 (Special Session). We concur and accordingly analyze the matter under the Workers' Compensation Act effective July 1, 1990. See Or Laws 1990 (Special Session), ch. 2, 54(2). Ida M. Walker, 43 Van Natta 1402 (1991).

Subsequent to the Referee's order, in Stanley Meyers, 43 Van Natta 2463 (1991), we held that under amended ORS 656.704(3) "matters concerning a claim" over which the Board and thus the Hearings Division has jurisdiction, do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. In this case, we find that 656.327, as amended, provides a procedure for resolution of this dispute.

At the time of claimant's injury, ORS 656.245(1) provided for purely palliative services for compensable injuries. Wait v. Montgomery Ward, Inc., 10 Or App 333 (1972). However, the legislature amended ORS 656.245(1) in 1990. As amended, it requires claimant's "attending physician," as defined by ORS 656.005, to request approval for palliative care from the insurer before such services are rendered and, if approval is not granted, authorizes the attending physician to request approval from the Director. Moreover, the amended definition of "attending physician" limits treatment allowable by a chiropractor, as an attending physician, to 30 days from the date of the first visit on the claim or 12 visits, whichever occurs first. ORS 656.005(12)(b)(B).

In Meyers, we also held that ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate or in violation of rules regarding the performance of medical services." We concluded that original jurisdiction over these disputes now lies with the Director. Stanley Meyers, supra.

Here, relying on the effective date of the new procedure for requesting authorization for palliative chiropractic care set forth in ORS 656.245, the insurer did not pay for claimant's chiropractic treatment. (Ex. 5). In effect, the insurer was contending that, because claimant's palliative chiropractic care after July 1, 1990 was not authorized pursuant to ORS 656.327, such care inappropriate. Inasmuch as ORS 656.327 grants original jurisdiction over such disputes to the Director, we conclude that resolution of this issue is not within the jurisdiction of the Hearings Division and, accordingly, we vacate the Referee's order as to this matter. See Joan E. Hathaway, 43 Van Natta 2730 (1991).

With regard to the assessed attorney fee, the insurer also argues on review that the Referee lacked jurisdiction to assess penalties and related fees under ORS 656.262(10) for the insurer's allegedly unreasonable failure to pay for claimant's chiropractic care within 60 days. While we agree that the Referee lacked jurisdiction under that provision, here, the fee was assessed under ORS 656.382(1). We recently noted in Ronald A. Stock, 43 Van Natta 1889 (1991) that a claimant may not seek both a penalty under ORS 656.262(10) and an assessed fee under ORS 656.382(1) for the same conduct. We held that, while the Director has exclusive jurisdiction in cases where the sole issue is a penalty and related fee for unreasonable conduct under ORS 656.262(10), where claimant raises a separate fee as the sole issue or alleges different conduct in support of a fee than in support of the penalty, then the Hearings Division maintains jurisdiction to decide whether a fee is warranted. Ronald A. Stock, supra.

In this case, claimant's attorney initially requested penalties and related fees under 656.262(10) for the insurer's allegedly unreasonable conduct in failing to pay claimant's chiropractor bills within 60 days. Later, he withdrew that request and raised as the sole issue an attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable resistance to the payment of claimant's chiropractor bills. We find that, under these circumstances, the Referee maintained jurisdiction over the attorney fee issue. See Ronald A. Stock, supra. However, after our de novo review of the record we, conclude that a fee is not warranted here and reverse the Referee's award.

Because it is relevant to the resolution of the attorney fee issue, we first address the insurer's argument that the Referee erred in admitting Exhibit 7 because it is not a "medical report." We review the Referee's ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

Here, claimant offered that exhibit, a check-the-box letter signed by claimant's chiropractor concerning the chiropractor's bills and the insurer's payments, to support her contention that the insurer had unreasonably resisted payment of claimant's chiropractor bills. Because we find that the exhibit was reasonably pertinent to claimant's allegation, we conclude that the Referee did not abuse his discretion by admitting it into evidence. See Ciriaco Sosa, 43 Van Natta 1713 (1991).

On the other hand, we do not believe that Exhibit 7 establishes that the insurer unreasonably resisted payment or refused to pay. Moreover, we find no evidence from which we can determine when the insurer received the chiropractor's billings nor has claimant established when the billings were mailed in order to take advantage of the presumption of receipt under ORS 40.135(1)(q). Absent that information, we cannot determine if the insurer unreasonably resisted payment of the billings. See Shari Hallberg, 42 Van Natta 2750 (1990). Accordingly, we reverse the Referee's attorney fee award.

ORDER

The Referee's order dated February 13, 1991 is vacated in part and reversed in part. That portion of the Referee's order which relates to claimant's chiropractic bills is vacated. The Referee's $250 attorney fee award is reversed.

In the Matter of the Compensation of
THOMAS E. EDISON, Claimant
WCB Case No. 90-12890
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

The SAIF Corporation has submitted a "Request for Review" of "Referee Tenenbaum's order dated February 7, 1992." Inasmuch as we issued an Order on Review on February 7, 1992 affirming Referee Tenenbaum's order, we interpret SAIF's request as a motion for reconsideration.

After further considering this matter, we continue to adhere to the reasoning and conclusions expressed in our prior order. Specifically, we continue to hold that: (1) claimant's hearing request from SAIF's denial was timely filed; (2) claimant's stroke was compensable; and (3) the Referee's $2,700 attorney fee award was reasonable.

Finally, we note that, in accordance with OAR 436-60-140(4) and 438-05-065, a carrier is required to give written notice of its denial by registered or certified mail with return receipt requested or by personal service meeting the requirements for service of a summons. In light of this requirement, we withdraw our special concurrence.

Accordingly, the Board's February 7, 1992 order is withdrawn. On reconsideration, as supplemented herein, the Board's order is adhered to and republished. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JESUS C. GONZALES, Claimant
WCB Case No. 90-12216
ORDER ON REVIEW
J. R. Perkins III, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Davis' order which: (1) declined to admit expert testimony at hearing; and (2) increased claimant's scheduled permanent disability award for a right knee injury from 30 percent (45 degrees), as awarded by a prior Determination Order and stipulation, to 34 percent (51 degrees). On review, the issues are admission of evidence and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Expert Testimony

Claimant objects to the Referee's decision to omit Dr. Donovan's testimony at hearing. We conclude that the decision was within the discretion of the Referee.

Parties are required by OAR 438-07-016 to provide notice of expert testimony not less than 10 days before a hearing. Failure to comply with the rule may be a ground for exclusion of expert testimony pursuant to OAR 438-07-016. Here, the insurer was not informed of Dr. Donovan's live testimony until 25 minutes before hearing. (Tr. 1, 6). The insurer asserted that it was prejudiced by the untimely disclosure on the basis that he was not prepared for such testimony and his ability to defend the case would be severely prejudiced. The Referee agreed, and accordingly, he excluded the expert testimony.

Under the circumstances, we do not find that the Referee abused his discretion by excluding the expert testimony.

Extent of Disability

We adopt the Referee's "Conclusions of Law and Opinion" on the issue of extent of scheduled permanent disability.

ORDER

The Referee's order dated April 30, 1991 is affirmed.

February 28, 1992 Cite as 44 Van Natta 371 (1992)

In the Matter of the Compensation of
KIM M. HARRISON, Claimant
WCB Case No. 91-05223
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Brown's order that declined to award an attorney fee under ORS 656.382(2) when the insurer withdrew its hearing request from a Department Order on Reconsideration. On review, claimant contends that she is entitled to a carrier-paid attorney fee under either ORS 656.382(2) or 656.386(1).

We affirm and adopt the order of the Referee with the following supplementation concerning claimant's contention that she should receive an attorney fee award under ORS 656.386(1).

The statute is premised on claimant finally prevailing against an order or decision denying a claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988). Here, it was the insurer, not claimant, who requested a hearing from the Director's Order on Reconsideration. Moreover, the Order on Reconsideration awarded, rather than denied, compensation. Thus, claimant has not satisfied the statutory prerequisites for an attorney fee award.

Relying on the recent amendment to ORS 656.386(1), claimant argues that she is entitled to an attorney fee award because her counsel was instrumental in

prompting the withdrawal of the insurer's hearing request from the Order on Reconsideration. The statutory amendment provides for an attorney fee award when claimant's attorney is instrumental in obtaining compensation for claimant without a hearing. Stating that "[t]he threat of a reduction in benefits to [her] was very real," claimant asserts that "[she] obtained compensation by not having the Determination Order of March 7, 1991 reinstated."

Claimant's attorney may well have been instrumental in prompting the withdrawal of the insurer's hearing request. Nevertheless, claimant's attorney's efforts and the insurer's withdrawal of its hearing request did not result in claimant's "obtaining" compensation without a hearing. Instead, as acknowledged by claimant, the insurer's withdrawal of its hearing request removed "[t]he threat of a reduction in [claimant's] benefits as granted by the Director's Order on Reconsideration." Such circumstances do not entitle claimant to an attorney fee award under ORS 656.386(1).

ORDER

The Referee's order dated August 13, 1991 is affirmed.

In the Matter of the Compensation of
MICHAEL E. MORRISON, Claimant
WCB Case No. 91-02271
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee T. Lavere Johnson's order that concluded that claimant's awards of scheduled permanent disability should be paid at the rate of $145 per degree. In its brief, the self-insured employer has objected to additional documents submitted by claimant in his brief. On review, the issues are remand and the rate of scheduled permanent disability. We deny remand and affirm.

FINDINGS OF FACT

We adopt the parties' stipulated facts.

CONCLUSIONS OF LAW AND OPINION

Remand

With his brief, claimant has submitted three documents that were not admitted into the record at hearing. Our review is limited to the record developed by the Referee. We may remand to the Referee for the taking of additional evidence if we determine that the record has 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 at the time of the hearing. Compton v. Weyerhaeuser, 301 Or 641 (1986). Because claimant had made no such showing, remand is not warranted. Accordingly, we exclude the three documents contained in claimant's brief and do not consider them on review.

Rate of Scheduled Permanent Disability

The Referee found that, under Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), awards of scheduled permanent disability made after May 7, 1990 should be paid at the rate of $305 per degree, regardless of the date of injury. He concluded, however, that the parties' stipulation precluded the payment at $305 per degree and that claimant's awards of scheduled permanent disability were properly paid in an amount equal to $145 per degree. We agree.

The procedural history of this case is important. Claimant's injury claim was closed by a September 13, 1990 Determination Order, which awarded 40 percent scheduled permanent partial disability and ordered the employer to pay claimant $8,700. After claimant requested a hearing, that award was increased by the parties' stipulation that claimant was entitled to an additional "10% scheduled permanent partial disability equal to 15 degrees ($2,175.00)[.]" (Ex. 2). In exchange for the increased award, claimant's request for hearing was dismissed with prejudice as to all issues raised or raisable.

Pursuant to the Determination Order and Stipulation, the employer paid claimant $8,700 and $2,175, respectively. Both amounts correspond to a rate of $145 per degree of disability awarded. On February 25, 1991, claimant commenced this action, asserting that his scheduled disability awards should have been paid at the rate of $305 per degree.

We first address the September 13, 1990 Determination Order. As stated above, claimant requested a hearing on that award seeking increased compensation. That hearing request, however, was later dismissed with prejudice as to all issues raised or raisable. Accordingly, that Determination Order has become final by operation of law and claimant is precluded now from litigating that issue. See Drews v. EBI Companies, 310 Or 134 (1990).

With regard to the parties' stipulation, whether or not claimant would be entitled to payment of his scheduled disability award at the rate of $305 per degree under Herron, supra, claimant entered into a contractual agreement that his increased award should be paid in an amount equal to $145 per degree. It is not our function to question the parties' agreement. See Evans v. Rookard, Inc., 85 Or App 213 (1987). Accordingly, claimant's requests for payment of the previous scheduled awards of compensation at $305 per degree is denied.

ORDER

The Referee's order dated June 4, 1991 is affirmed.

February 28, 1992 Cite as 44 Van Natta 373 (1992)

In the Matter of the Compensation of
JAMES E. NICCUM, Claimant
WCB Case No. 90-17616
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial of his proposed back surgery; and (2) upheld SAIF's denial of his aggravation claim for his current low back condition. On

review, the issues are jurisdiction, medical services and aggravation. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the second paragraph of the ultimate findings of fact.

ULTIMATE FINDINGS OF FACT

The Hearings Division of the Workers' Compensation Board did not have jurisdiction to hear the matter regarding authorization for proposed medical treatment.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Jurisdiction

The Referee concluded that claimant's proposed back surgery was not reasonable or necessary. We find that the Referee lacked jurisdiction over the issue of the employer's denial concerning the proposed surgery. Subsequent to the Referee's order, we concluded that, under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. Stanley Meyers, 43 Van Natta 2643 (1991). ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Moreover, we have recently held that disputes regarding proposed medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992). Thus, the fact that the dispute here involved a proposed future surgery rather than a current treatment does not vest jurisdiction in the Hearings Division. Accordingly, inasmuch as SAIF's denial concerning the proposed surgery did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate the Referee's order and dismiss claimant's hearing request as to that issue. See Kevin S. Keller, supra; Stanley Meyers, supra.

Aggravation

To establish a compensable aggravation claim for his current low back condition, claimant must prove with objective medical evidence that his accepted condition has worsened since the last arrangement or award of compensation. ORS 656.273; Robert E. Leatherman, 43 Van Natta 1677 (1991).

Under such circumstances, we conclude that the Referee correctly found that there was a lack of objective findings of a worsened condition since claimant's last arrangement or award of compensation. Accordingly, claimant has failed to establish a compensable aggravation for his current low back condition.

ORDER

The Referee's order dated April 30, 1991 is vacated in part and affirmed in part. That portion of the Referee's order that upheld the SAIF Corporation's denial of claimant's low back surgery is vacated. Claimant's hearing request on that denial is dismissed for lack of jurisdiction. The remainder of the order is affirmed.

February 28, 1992 Cite as 44 Van Natta 375 (1992)

In the Matter of the Compensation of
DUANE R. PAXTON, Claimant
WCB Case Nos. 88-18070 & 88-17363
ORDER ON REVIEW
Karen Werner, Claimant Attorney
Daryl Nelson, Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant and Liberty Northwest Insurance Corporation request review of Arbitrator Otto's order that: (1) set aside Liberty's denial of claimant's aggravation claim for a carpal tunnel syndrome condition; and (2) upheld Aetna Casualty Company's denial of claimant's occupational disease claim for the same condition. Aetna has filed a motion to strike claimant's reply brief for untimely filing. On review, the issues are timeliness and responsibility. We affirm.

We summarize the Arbitrator's findings. Claimant worked as a machinist for Liberty's insured. His work involved repetitive hand and wrist motion. In February 1986, he began to experience tingling and cramping in both hands and sought medical treatment. Shortly thereafter, he underwent carpal tunnel surgery on both wrists. He returned to regular work in May 1986, and his claim was closed without permanent disability.

In July 1987, claimant began working for Aetna's insured as a toolmaker. His work was similar to his prior work and also required significant use of the hands and wrists. In July 1988, he began to experience electrical shock sensations and tingling in both hands. He subsequently filed claims against both carriers.

Liberty denied responsibility on October 5, 1988, asserting that claimant had sustained a new injury with Aetna's insured. Aetna denied responsibility on November 1, 1988. Claimant timely appealed both denials. On February 23, 1989, an order issued pursuant to ORS 656.307, designating Liberty as the paying agent pending the outcome of the arbitration proceeding.

CONCLUSIONS OF LAW AND REASONING

Timeliness

Aetna has moved to strike claimant's reply brief on the basis that it was not filed within 14 days of the mailing of its July 3, 1991 respondent's brief.

It relies on the July 19, 1991 postmark on the envelope from which the reply brief was received. We deny the motion.

OAR 438-05-046(1) provides that reply briefs filed with the Board are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." In this case, the certificate of service attached to the reply brief indicates that it was deposited in the mail on July 17, 1991. Accordingly, under the applicable administrative rule, claimant's reply brief was timely filed.

Responsibility

Claimant and Liberty seek review of the Arbitrator's decision assigning responsibility to Liberty. We review the Arbitrator's decision pursuant to ORS 656.307(2), which provides, in part:

> "Review of the determination of the arbitrator by the board * * * is limited to questions of law and is not thereafter subject to review by any other court or administrative body. However, if the claimant can establish, on the arbitration record, that the determination resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator by the board * * * shall be as provided for matters concerning a claim.

Claimant contends that our review of the Arbitrator's decision in this case is de novo. He contends that the determination resolves a matter concerning a claim, because a new five-year period of aggravation rights would accrue under ORS 656.273(4) if he were successful in establishing a "new injury." We disagree.

ORS 656.704(3) defines a matter concerning a claim as "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." (Emphasis supplied). The vesting of new aggravation rights does not place claimant's right to compensation or the amount thereof, "directly in issue" in this proceeding. Furthermore, claimant's rate of temporary total disability will be unaffected by the assignment of responsibility for his claim. Compare Jon E. Robinson, 42 Van Natta 512 (1990). Therefore, we review the Arbitrator's decision solely for errors of law.

Given the Arbitrator's finding that claimant's work at Aetna's insured did not cause a pathological worsening of the underlying condition, the Arbitrator correctly concluded that Liberty remained responsible for claimant's carpal tunnel syndrome condition based on the applicable law. See Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). Accordingly, we affirm the Arbitrator's decision.

ORDER

The Arbitrator's order dated March 28, 1991 is affirmed.

In the Matter of the Compensation of
DORIS M. SEIBERT, Claimant
WCB Case No. 90-13759
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Thye's order that: (1) found that claimant had withdrawn from the work force at the time of her aggravation claim for a right knee condition; and (2) declined to award temporary disability during claimant's aggravation claim. On review, the issue is temporary disability.

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

The Referee found that claimant had withdrawn from the work force prior to the worsening of her compensable right knee condition for which she underwent surgery in January 1989. We agree.

In order to receive temporary total disability benefits for a worsening of a compensable injury, claimant must have been in the work force at the time of the worsening. Cutright v. Weyerhaeuser, 299 Or 290 (1985). Claimant is deemed in the work force if: (1) she was engaged in regular gainful employment at the time of the worsening; (2) although not employed, she was willing to work and was making reasonable efforts to obtain employment; or (3) although willing to work, she was not looking for employment for reasons related to the compensable injury, where such efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

In this case, the Referee found, and we agree, that claimant had withdrawn from the work force prior to the time of the worsening in January 1989. Claimant had voluntarily retired at the end of 1986 for reasons unrelated to her November 1986 injury, and she began receiving PERS pension and Social Security benefits. However, we must also determine whether claimant subsequently decided to reenter the work force. In that case, she would not be barred from receiving temporary disability benefits solely because she had earlier voluntarily retired from the work force. SAIF v. Stephen, 308 Or 41, 47 (1989).

In this case, however, claimant failed to establish that she was in the work force at the time of the aggravation under any of the criteria identified in Dawkins, supra. First, the Referee found, and we agree, that claimant was not engaged in regular gainful employment at the time of the aggravation. Claimant contends that she was self-employed in managing a 5-unit apartment complex she and her husband purchased in November 1987. The specific activities she performed included keeping records, writing checks, going to the bank, occasionally picking up rent payments, showing apartments to prospective renters, and arranging for services to be performed in maintaining the apartments. (Tr. at 8-9, and 11-13). However, claimant testified that she shared these tasks with her husband, and the record establishes only that claimant did more bookkeeping than her husband. (Tr. at 14; see also Tr. at 13, 26). The bookkeeping is not a daily responsibility and can be done intermittently. (Tr. at 25). Claimant did not receive wages or even wage replacement. (Tr. at 24).

Self-employment may constitute regular gainful employment, and claimant need not prove a particular loss in wages to be entitled to temporary disability benefits. Carlos C. Santibanez, 43 Van Natta 2685 (1991), citing International

Paper Co. v. Hubbard, 109 Or App 452 (1991). However, in this case, the limited and irregular activities claimant performed jointly with her husband, for which she received no wages or other remuneration, do not constitute regular gainful employment. See e.g., Harris v. SAIF, 292 Or 683, 693-95 (1982); Elsie D. Rios, 43 Van Natta 2490, 2491 (1991). In Harris, the court held that where the claimant earned money from investments and property management but worked an inconsistent and variable schedule, he was not regularly and gainfully employed so as to revoke permanent and total disability. In Rios, we held that remuneration in the form of room, board and a monthly stipend did not constitute regular and gainful employment where the claimant worked only when she was capable of doing so. In light of these holdings, we agree with the Referee that claimant was not engaged in regular gainful employment at the time of her aggravation.

Next, we determine whether claimant was willing to work and whether she made reasonable efforts to obtain employment. The Referee found, and we agree, that claimant had made no serious effort to obtain employment after she retired in December 1986. She visited an unemployment office once shortly before a hearing in September 1988, discussed the possibility of teaching GED classes, and read the want ads regularly, but she never made any job applications. Under such circumstances, we find that claimant failed to establish that she made reasonable efforts to obtain employment.

Finally, we must determine whether claimant was nevertheless willing to work, but was not making reasonable efforts because of her work-related injury, where such efforts would be futile. Fendrich v. Curry County, 110 Or App 409, 413 (1991). Claimant testified that she intended to begin her own antique sales business after she retired in December 1986, but was prevented from doing so by the compensable knee injury. (Tr. at 4-5). Although claimant testified that she still goes back and forth on whether to open the business, in August 1988 she had given up on the plan because of her knee. (Tr. at 5-6). A vocational assessment in September 1988 identified several jobs consistent with claimant's physical restrictions and transferable skills. (Ex. 15). However, claimant made no job applications. Therefore, we conclude that claimant failed to establish both that she was willing to work, and that reasonable job search efforts would be futile due to her compensable injury.

Accordingly, we agree with the Referee's finding that claimant had withdrawn from the work force prior to her worsening. Therefore, she is not entitled to receive temporary total disability benefits.

ORDER

The Referee's order dated March 28, 1991 is affirmed.

February 28, 1992 Cite as 44 Van Natta 378 (1992)

In the Matter of the Compensation of
DARRELL D. TUTTLE, Claimant
WCB Case No. 90-20785
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Bethlahmy's order that declined to award temporary disability. On review, the issue is temporary disability compensation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions and supplementation.

We do not adopt paragraphs 12 and 13.

ULTIMATE FINDINGS OF FACT

Claimant became temporarily, totally disabled on October 17, 1990 as a result of his compensable psychiatric condition. He had not become psychiatrically medically stationary and his psychiatric claim had not been closed. This temporary disability status continued for three weeks.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee found that claimant was not entitled to temporary total disability. We disagree.

Claimant has not been determined to be psychiatrically medically stationary; therefore, his psychiatric claim has never been closed. Thus, contrary to the employer's argument, he need not establish an aggravation or a worsening of his psychiatric condition in order to establish entitlement to temporary disability due to that condition.

Whether a claimant is entitled to temporary total disability benefits depends on whether a preponderance of the evidence indicates that he was disabled during the time due to the compensable claim. ORS 656.210; Botefur v. City of Creswell, 94 Or App 627 (1987).

Claimant's manager suggested that claimant wear ear muffs in addition to his ear maskers at work. Claimant was upset by this advice and did not think that it would be effective. However, on October 16, 1990, upon his return from vacation, he tried wearing both ear maskers and ear muffs. As a result, he suffered an anxiety attack, becoming dizzy, feeling as if he would pass out, and having pounding in his chest. He left work around 11:30 a.m. that day and saw Dr. Day the next day about this condition.

Dr. Day opined that when he saw claimant on October 17, 1990, claimant's symptoms of agitation and depression were twice again as much as when Day had previously examined claimant. (Ex. 77-14). Dr. Day also stated that three weeks of time loss was authorized due to the psychiatric condition and that subsequent time loss was due to the carpal tunnel surgery. (Exs. 77-12, -13). The carpal tunnel condition is in "own motion" status.

Dr. Turco examined claimant on November 2, 1990. (Ex. 72). He testified that claimant left work due to his tinnitus condition and that he did not need to be away from work for psychiatric reasons. (Tr. 45, 47).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there is no reason not to defer to Dr.

Day. He was able to examine claimant closer in time to the October 16 incident, and he was able to compare claimant's condition on October 17 to that of his past examinations. Dr. Turco examined claimant more than two weeks after the October incident. Furthermore, Dr. Turco acknowledged that the October 1990 incident was psychiatrically threatening to claimant. (Tr. 53).

On January 15, 1991, Mr. Colistro, treating clinical social worker, opined that it remained necessary for claimant to be off work due to his suicidal ideation and impulses to commit violent acts. (Ex. 75A-3). On October 17, 1990, Mr. Colistro examined claimant and stated that his suicidal ideation had returned. (Ex. 66). However, Mr. Colistro's chart notes since that date note improvement and the absence of suicidal thoughts. (Exs. 69, 70A, 72A, 73A, 73B). Given the fact that these chart notes do not mention the problems that Mr. Colistro cites as the reasons continued time loss is necessary, we do not find Mr. Colistro's opinion persuasive.

Accordingly, relying on Dr. Day's well-reasoned opinion, we conclude that claimant is entitled to temporary disability benefits for three weeks, beginning October 17, 1990.

ORDER

The Referee's order dated April 22, 1991 is reversed. Claimant is awarded temporary total disability compensation for three weeks, beginning October 17, 1990. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
ROSE M. WAKEFIELD, Claimant
WCB Case Nos. 90-15618 & 90-00160
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
VavRosky, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) upheld Royal Insurance Company of America's denial of her aggravation claim for a left ankle condition; and (2) upheld Sedgwick James & Company's denial of her "new injury" claim for the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

At hearing, counsel for Royal Insurance indicated that it was denying claimant's condition on both a worsening and causal relationship basis. (Tr. 5).

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions and reasoning as set forth in the Referee's order with the following modification.

The Referee found that claimant's condition was causally related to her 1982 injury with Royal Insurance. However, she also found that claimant's compensable condition had not worsened, therefore, she upheld Royal Insurance's denial.

We agree that claimant's compensable condition is causally related to the 1982 compensable injury. We further find that Royal Insurance denied claimant's condition based on a lack of causal relationship. Therefore, we conclude that Royal Insurance's denial should be set aside.

In reaching this conclusion, we are aware of Royal Insurance's argument that it only denied that claimant's condition had worsened. However, claimant's aggravation rights as to her 1982 compensable injury had expired. ORS 656.273(4); 656.278(2). Therefore, the only basis for Royal Insurance's denial that was properly before the Referee was that claimant's condition and her resulting medical treatment under ORS 656.245 were not causally related to the 1982 injury.

Inasmuch as we have found that Royal Insurance's denial was based on causation and we have herein set aside that denial, claimant's counsel is entitled to an assessed attorney fee pursuant to ORS 656.386(1).

Claimant is entitled to an assessed attorney fee for prevailing over Royal Insurance Company's causation denial. 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 attorney fee for claimant's counsel's services at hearing and on review concerning the ORS 656.245 compensability issue is $1,200, to be paid by Royal Insurance Company. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 22, 1991 is reversed in part and affirmed in part. That portion that upheld Royal Insurance Company of America's denial reversed. Royal Insurance Company of America's denial insofar as it pertained to claimant's medical services is set aside and the claim is remanded to it processing according to law. For services at hearing and on review concerning Royal Insurance Company of America's denial, claimant's counsel is awarded an assessed fee of $1,200, payable by Royal Insurance Company of America. The remainder of the order is affirmed.

February 28, 1992 Cite as 44 Van Natta 381 (1992)

In the Matter of the Compensation of
ROBERTA J. WILSON, Claimant
WCB Case No. 90-15449
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Claimant requests reconsideration of our January 31, 1992 Order on Review. The employer has cross-requested reconsideration. In order to allow sufficient time to consider the motions, the above-noted Board order is withdrawn.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOAN M. GALLO, Claimant
WCB Case No. 89-17443
ORDER ON REMAND
Claudette Yost, Claimant Attorney
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Rogue Valley Medical Center v. Gallo, 109 Or App 698 (1991). The court reversed our prior order which found claimant's occupational disease claim for a cervical spine condition compensable because she had established that her work activities were a material contributing cause of the exacerbation of her cervical condition. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our February 8, 1991 order. We do not republish our prior "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

In our prior order, we found that claimant's work activities were a material contributing cause of the exacerbation of her cervical spine condition. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that such a finding established the compensability of her occupational disease claim.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that her work activities were the major contributing cause of her condition or the worsening of her underlying condition. Aetna Casualty co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of her condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991).

Here, claimant contends that the opinion of her treating neurosurgeon, Dr. Purtzer, establishes that her work activity as a medical transcriptionist was the major contributing cause of her cervical spondylosis condition. We do not find Purtzer's opinion sufficient to satisfy the statutory requirement for compensability of an occupational disease claim.

Dr. Purtzer supports a causal relationship between claimant's work activities and the development of her cervical spondylosis condition. Nevertheless, Purtzer conceded that "[i]t wouldn't have been shocking" that a 52-year-old post-menopausal woman would develop such a condition. Although Purtzer did not consider these degenerative reasons to be the major contributing cause of claimant's spondylosis, he acknowledged that any activity placing claimant's head in a "forward and looking down" position would be causative or contributory to the condition. Notwithstanding the recognition of these non-work contributors, Dr. Purtzer "wouldn't necessary [sic] say that that type of reasoning is going to say that [claimant's] work did not materially contribute to the spondylosis."

Magic words are not required to establish the compensability of a claim. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). However, considering Dr. Purtzer's acknowledgment of the potential contribution of other non-work

related factors to claimant's spondylosis condition and his failure to state that claimant's work activities were the major contributing cause of her condition, we do not find the treating physician's opinion sufficient to prove the compensability of claimant's occupational disease claim for her cervical spondylosis condition. Consequently, the insurer's denial is upheld.

Accordingly, on reconsideration, we affirm the Referee's order dated March 28, 1990.

March 2, 1992 Cite as 44 Van Natta 383 (1992)

In the Matter of the Compensation of
CHERIE L. MORAN, Claimant
WCB Case No. 90-16097
ORDER OF ABATEMENT
Myrick, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The self-insured employer has requested reconsideration of our February 14, 1992 Order on Review. Specifically, the employer contends that we erred in affirming the Referee's award of a penalty for an allegedly unreasonable denial.

In order to allow sufficient time to consider the motion, the above-noted Board order is withdrawn. Claimant is requested to file a response to the motion within ten days. Thereafter, the matter will be taken under advisement.

IT IS SO ORDERED.

March 2, 1992 Cite as 44 Van Natta 383 (1992)

In the Matter of the Compensation of
CONSTANCE L. RODRIGUES, Claimant
WCB Case No. 90-03925
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Mongrain's order which set aside its denial of claimant's Bell's palsy condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

In his deposition, Dr. Sloan testified and we find that claimant did not have a respiratory or other viral infection shortly before she contracted chickenpox as a result of her exposure to herpes zoster.

ULTIMATE FINDINGS OF FACT

Claimant's Bell's palsy condition was caused by the same viral agent as the accepted condition and is intrinsically related to the compensable condition and; therefore, is compensable. Even if found to be a consequential disease, the accepted condition is the major contributing cause of the Bell's palsy condition and, as such, is compensable.

CONCLUSIONS OF LAW AND OPINION

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

The Referee found claimant's Bell's palsy condition compensable as a consequence of her previous work related exposure to chickenpox. The question of her current condition, (Bell's palsy), and its relationship to the accepted condition, (chickenpox), presents a complex medical question that requires expert medical opinion in order for claimant to meet her burden of proof. Uris v. Compensation Department, 247 Or 420 (1967), Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

The record contains the opinions of several doctors. The treating physician, Dr. Sloan, indicates that he cannot provide a cause and effect relationship between the chickenpox and Bell's palsy; however, he admits to being a general practice physician and defers to the findings of the specialists. Claimant was examined by two other physicians on referral from Dr. Sloan. A third opinion is offered by a Dr. Girod. We conclude that Dr. Girod's opinion is based on incomplete information. Dr. Girod concedes that his opinion is based upon "scant medical information." Moreover, Dr. Girod did not examine claimant. He opines that the chickenpox is a possible cause of the Bell's palsy, but also refers to the fact that claimant suffered from an earlier viral infection that is not in the medical record and denied by the treating physician.

Dr. Navada examined claimant on January 16, 1991. He also found a temporal relationship between the chickenpox and Bell's palsy, but did not feel that the palsy condition arose from the chickenpox "per se." Dr. Norton, SAIF's medical advisor, agreed with Dr. Navada's opinion, but Dr. Norton qualified his concurrence by noting he is not an expert on infectious disease or Bell's palsy etiology. To this point, claimant has failed to carry her burden of proof because all the above opinions are characterizing the palsy as either idiopathic in origin or only temporally related to the chickenpox.

Dr. Gancher examined claimant in June of 1990. He states, "I feel that Mrs. Rodrigues had multiple cranial neuropathies due to varicella zoster" (chickenpox). In response to claimant's counsel, he further elaborates, "[f]irst, I do think that her exposure to varicella zoster caused her chicken pox and, in my opinion, also caused her facial palsy. Facial palsy is listed in at least one textbook of neurology as an occasional application of chicken pox." Dr. Gancher is a specialist. He examined claimant and reviewed the medical reports from both Dr. Girod and Dr. Navada. We find his opinion to be well-reasoned and persuasive as to etiology and causation of both the accepted condition and the Bell's palsy.

On review, SAIF first contends that, in order to establish a compensable claim, claimant has the burden of proving that her previously compensable injury is the major contributing cause of her current consequential condition. ORS 656.005(7)(a)(A). We disagree. In Julie K. Gasperino, 43 Van Natta 1151 (1991), we held that the 1990 amendments to the definition of a compensable injury do not affect the standard of compensability for conditions intrinsically related to the underlying industrial accident.

In the case before us, even Drs. Girod and Navada, upon whom SAIF relies, note that palsy is linked to viral infections and even possibly to the accepted viral condition of chickenpox. It is clear from Dr. Gancher's opinion that the cause of both the accepted condition and the Bell's palsy is the viral agent, varicella zoster. Since the causative agent of both is the virus, we do not find the Bell's palsy to be a consequential condition of the accepted condition, but instead find them intrinsically related.

Even were we to consider it as a consequential condition, the accepted condition (chickenpox) is the major contributing cause of the palsy, as noted by Dr. Gancher's opinion. (We note that both Dr. Navada and Dr. Girod find a temporal and possible relationship between the palsy and accepted condition).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the compensability issue is $1,200, 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 June 13, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $1,200, payable by the SAIF Corporation.

March 2, 1992 Cite as 44 Van Natta 385 (1992)

In the Matter of the Compensation of
FRED C. SUMPTER, Claimant
WCB Case No. 91-02149
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Cooney, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Peterson's order that affirmed a Determination Order which had awarded no permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability.

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

We note that, because claimant became medically stationary prior to July 1, 1990, the standards in effect under WCD Admin. Order 6-1988 apply to this case. OAR 436-35-003.

Dr. Solomon, treating chiropractor, presents the only medical report after claimant became medically stationary. (Ex. 30). However, we agree with the Referee that this report is unpersuasive.

Dr. Solomon last treated claimant in August 1989, at which time he found claimant medically stationary and released him to return to his regular work without restrictions. Claimant received no further medical treatment after that date. (Tr. 15, 17). Dr. Solomon next examined claimant on May 6, 1991, not for treatment purposes, but solely for the purpose of updating his current medical status. (Ex. 30).

In his May 1991 report, Dr. Solomon opined that claimant had a chronic condition limiting repetitive use of his back and noted that claimant had been unable to return to his usual occupation, which he understood to be topping and trimming trees. However, claimant's usual occupation was as a painter's

apprentice and claimant testified that he had made no attempt to return to that work. Furthermore, Solomon does not explain the inconsistency between his finding of a chronic condition on the one hand, and on the other, his earlier decision to release claimant to regular work without restrictions, and the fact that claimant did not seek medical treatment for over two years. In addition, claimant testified that his back has remained the same since he last saw Dr. Solomon in August 1989. (Tr. 17).

Furthermore, the range of motion findings listed by Dr. Solomon are not convertible to a rating under the "standards." See Ronald E. Ingram, 44 Van Natta 313 (1992).

For these reasons, in addition to those cited by the Referee, we find that Dr. Solomon's report is unpersuasive. Accordingly, we conclude that claimant has not established any permanent impairment due to his compensable injury.

ORDER

The Referee's order dated June 3, 1991 is affirmed.

In the Matter of the Compensation OF
DAVID M. PETERSON, Claimant
WCB Case Nos. 90-15663 & 90-20333
ORDER ON REVIEW
Max Rae, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Quillinan's order that: (1) set aside Crawford & Company's (Crawford) "de facto" denial of claimant's aggravation claim for a low back condition; (2) declined to include the medical benefits due in the assessment of penalties and attorney fees against Crawford for its failure to timely accept or deny the aggravation claim; and (3) declined to assess a penalty against Aetna Casualty Co. (Aetna) for failing to send claimant's attorney a copy of its denial of claimant's "new injury" claim. Crawford cross-requests review of those portions of the order that: (1) set aside its "de facto" denial of claimant's aggravation claim for a low back condition; and (2) upheld Aetna's denial of claimant's "new injury" claim for the same condition. On review, the issues are responsibility, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of her first two ultimate findings of fact.

FINDINGS OF ULTIMATE FACT

Claimant did not suffer a "new injury" on April 13, 1990 while Aetna was at risk.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Relying on case law prior to the 1990 amendments, the Referee found that Crawford had not established that claimant's work activities while Aetna was at risk contributed to a pathological worsening of claimant's compensable

worsening. Therefore, she concluded that Crawford remained responsible for claimant's current condition. We agree that Crawford is responsible; however, we apply the following analysis.

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

We have interpreted Section 49 of the amended law to mean that, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991); Ronald L. Rushton, 44 Van Natta 124 (1992). Thus in this case, Crawford, as the last insured against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, Crawford has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working when Aetna was at risk.

By a May 1988 stipulation, Crawford accepted claimant's lumbar and cervical strain. (Ex. 8a). Claimant had not totally recovered from these strains and continued to receive regular chiropractic treatments. Additionally, he continued to experience periodic flare ups due to his strenuous work activities. Dr. McFie began treating claimant on January 18, 1988 and continued to provide regular chiropractic treatments.

On April 13, 1990, after Aetna became the insurer, claimant was working with a pick ax and had sudden pain in his lower back and buttocks. (Tr. 13). The pain was so severe that he could not get into the company van and later had to have help getting into his house and the chiropractor's office. (Tr. 16, 17). He went to Dr. McFie that day.

Upon examination, Dr. McFie noted an abnormal Achilles tendon reflex, a neurological symptom. As a result of this neurological symptom, Dr. McFie ordered a CT scan which showed annulus bulges at L2-3, L3-4 and L5-S1. (Ex. 9). Dr. McFie also noted radicular pain as far as the knee. Because the CT scan ruled out any L5 nerve root involvement, Dr. McFie reasoned that the L5 nerve was being entrapped somewhere within the muscle spasm. (Ex. 29-24).

Dr. McFie also noted widespread muscle spasms. Because of the chronic spasm, claimant had no range of motion without pain. However, by April 20, 1990, Dr. McFie measured claimant's range of motion and noted that he had radicular pain only in the evening. (Exs. 29-22, 29-23). Dr. McFie released claimant from work for a week. On April 16, 1990, Dr. Rogosin, family physician, examined claimant and found a moderate amount of muscle spasm over the lumbar spine with no pain radiating into the legs. (Ex. 10).

Dr. McFie opined that the mild protrusions of the annuli and the radicular pain were consistent with a pathological worsening. (Ex. 26). However, he also noted that these bulges could have been present prior to the April 13, 1990 incident because there was no prior CT scan for comparison. He also opined that the April 13, 1990 incident was the major contributing cause of claimant's increased disability and increased need for treatment. He based this opinion, in part, on his observation that claimant's problem area had expanded from the knees up to the thoracic spine, whereas before it was limited to the gluteal, sacral and lumbar areas. (Ex. 29-25). However, Dr. McFie had adjusted claimant's mid-thoracic spine prior to the April 1990 incident.

Aetna argues that Dr. McFie's opinion is inaccurate in that, at one point, he stated that claimant had a broader area of instability after the April 13, 1990 incident because it involved a higher area of the lumbar spine, into L3 and L4. However, Aetna points out that claimant had received chiropractic adjustments to L3 and L4 from Dr. McFie in the past. We agree that Dr. McFie's opinion contains these inconsistencies.

More importantly, in order to shift responsibility, Crawford must establish that claimant suffered a new injury in the April 1990 incident. Dr. McFie does not opine that a new injury occurred. (Exs. 16, 26, 29). Instead, we interpret McFie's conclusion to be that claimant is suffering from a chronic instability condition related to his 1986 injury with Crawford, the symptoms of which were increased as a result of his April 1990 work incident. Accordingly, we conclude that Dr. McFie's opinion does not establish a "new injury" while Aetna was at risk.

Dr. Young, attending physician, provides the only other opinion relating to causation. Dr. Young examined claimant only once, several months after the April 1990 incident, and noted no radicular involvement at that time. (Ex. 28-9). In a report dated November 10, 1990, Dr. Young opined that claimant's present injuries were directly related to the 1986 on the job injury. (Ex. 25). However, in a report dated December 17, 1990, Dr. Young opined that, based on claimant's history and physical findings, the April 13, 1990 incident created a significant new injury. (Ex. 27). Because Dr. Young did not explain this change of opinion, we find this unexplained change of opinion unpersuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980); Raul A. Herrera, 40 Van Natta 1281 (1988).

Furthermore, during his deposition, Dr. Young stated that he could not state with a great deal of certainty at this point whether or not there was a new injury. (Ex. 28-10). He noted that Dr. McFie's neurological findings were as likely to be the result of the severe spasm causing transitory irritation as any other explanation, given the absence of other neurological findings showing irritation of the disc. (Ex. 28-11). He also stated that the April 1990 incident was a significant aggravation of the preexisting problem. (Ex. 28-26). Because of the inconsistencies in Dr. Young's opinion, we do not find it persuasive and, accordingly, give it little weight. See David H. Olson Jr., 42 Van Natta 1336 (1990).

We find that, on this record, Crawford has not established that claimant sustained a "new compensable injury" on April 13, 1990. Therefore, responsibility does not shift to Aetna.

Penalties and Attorney Fees

Aetna

The Referee declined to assess penalties and attorney fees against Aetna for its failure to send claimant's attorney a copy of its denial. However, she found that this failure established "good cause" for claimant's untimely hearing request on Aetna's denial. Claimant argues that he is entitled to penalties and attorney fees for Aetna's unreasonable conduct. We disagree.

We have affirmed the Referee's order finding that Aetna is not responsible for the claim. Therefore, the claim is not compensable against Aetna. Hence, there can be no amounts "then due" upon which to base a penalty pursuant to ORS 656.262(10).

Pursuant to ORS 656.382(1), an attorney fee is allowed if an insurer "unreasonably resists the payment of compensation." Here, because the claim is not compensable against Aetna, there can be no unreasonable resistance of

payment of compensation by Aetna. See Randall v. Liberty NW Ins. Corp., 107 Or App 599 (1991).

Crawford

We adopt the Referee's reasoning and conclusion regarding the issue of limiting the penalty to unpaid time loss and awarding one-half of that penalty to claimant's attorney, in lieu of an attorney fee. See Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991).

ORDER

The Referee's order dated March 22, 1991 is affirmed.

March 5, 1992 Cite as 44 Van Natta 389 (1992)

In the Matter of the Compensation of
ARNOLD G. BARTLEY, Claimant
WCB Case No. 90-17783
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Black's order which upheld the SAIF Corporation's partial denial of a claim for cervical radiculopathy and/or carpal tunnel condition and cervical surgery. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the findings of the Referee.

CONCLUSIONS OF LAW

We adopt the reasoning of the Referee, with the following additional comment. Although claimant had complaints of numbness in two digits in February 1989, presumably existing since the late 1988 and early 1989 injuries, this is insufficient to establish that his later neck complaints were materially related to those injuries. Given the fact that osteophytes, such as claimant had, take a long time to form, and in light of Dr. Freeman's failure to address that fact we conclude that there is insufficient persuasive evidence to establish that claimant's compensable injury or injuries were a material contributing cause of the cervical radiculopathy for which he later had surgery. Additionally, the medical evidence does not support a diagnosis of carpal tunnel syndrome.

We conclude claimant has failed to establish compensable cervical radiculopathy or carpal tunnel conditions.

ORDER

The Referee's order dated May 31, 1991 is affirmed.

In the Matter of the Compensation of
DONALD H. BECKER, Claimant
WCB Case Nos. 90-17820 & 90-13596
ORDER ON REVIEW
Karen Werner, Claimant Attorney
Daryl Nelson, Defense Attorney
Coons & Cole, Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Davis' order that: (1) dismissed claimant's request for hearing concerning the compensability of an alleged February 28, 1990 low back injury; and (2) upheld the insurer's denials of his aggravation and new injury claims for a current low back condition. On review, the issues are timeliness and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not his "Findings of Ultimate Facts," with the following modification and supplementation.

The paragraph which begins on page two and continues on to page three is replaced with the following:

On the morning of February 28, 1990, claimant poled logs for the employer. He went to the warming shack to take a break at about 9:00 a.m. and felt sudden sharp low back pain as he sat down. Two co-workers witnessed claimant's reaction to the onset of low back pain. Sometime before noon, claimant asked his foreman, Jim Reed, if he could go home, because his back "hurt like hell." Reed told claimant that he could go home. Claimant went home at lunch time and did not return to work that day.

The employer received notice of the February 28, 1990 injury from Dr. Herscher on March 28, 1990.

ULTIMATE FINDINGS OF FACT

Claimant's new injury claim was timely filed.

The work incident on February 28, 1990 was a material contributing cause of claimant's subsequent low back condition. The work incident was the major contributing cause of claimant's disability and need for medical services for his low back from February 28, 1990 until April 26, 1990.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee found that the employer did not have notice of the claimed log pond incident of February 1990 until mid-July 1990 and, consequently, that claimant's injury claim was time barred. We disagree.

ORS 656.265(1) requires that a claimant give an employer notice of an accident resulting in injury within 30 days. Failure to give timely notice bars the claim, unless the employer had knowledge of the injury or has not been prejudiced by its failure to receive notice. ORS 656.265(4). "Notice of an accident resulting in injury," includes sufficient facts to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate. Argonaut Ins. Co. v. Mock, 95 Or App

1, rev den 308 Or 79 (1989). It is claimant's burden to establish that his claims were timely filed. See Marty Winn, 42 Van Natta 1013 (1990). If the claim was not timely filed, the burden is on the employer to prove prejudice due to lack of notice. Inkley v. Forest Fiber Products Co., 288 Or 337, 348 (1980).

In the present case, claimant did not submit a written claim form for his injury until July 1990. However, the employer received Dr. Herscher's March 8, 1990 chart note on March 28, 1990. (See Ex. 17). The first line of the doctor's note reports: "[Claimant] hurt low back while polling [sic] logs." (Id.) Claimant's work duties included poling logs, and there is no evidence that claimant engaged in that activity other than at work. Therefore, we find that the above-quoted report contained sufficient facts to trigger the employer's duty to engage in further investigation. Argonaut Ins. Co. v. Mock, supra. Inasmuch as the employer received Hersher's chart notes 28 days after February 28, 1990, the date of the claimed incident, we conclude that the notice was timely.

Moreover, even if claimant failed to give timely notice of the work incident, to avoid liability, the employer must prove prejudice due to lack of such notice. In this case, the employer argues that it was prejudiced because it had no opportunity to have claimant examined by an independent medical examiner (IME) and that it was further prejudiced by witnesses' (claimant's and foreman Jim Reed's) memory problems. We are not so persuaded. First, if anyone was prejudiced by witnesses' memory loss, it was claimant, not the employer. Second, inasmuch as more than seven months passed between the employer's receipt of Herscher's chart note and hearing, we conclude that the employer had ample opportunity to have claimant examined by a physician of its choice. Accordingly, claimant's injury claim is not barred due to lack of timely notice.

Compensability-new injury claim

Based on claimant's testimony and Herscher's uncontradicted report that claimant "hurt his back while polling [sic] logs," we conclude that claimant has established the compensability of a February 28, 1990 injurious event, by proving that that event was a material cause of his subsequent disability and need for medical treatment for his back. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). The parties agreed at hearing that the basic issue was the compensability of claimant's current low back condition. (Tr. 2). Accordingly, because claimant's low back condition preexisted his 1990 compensable injury, (see Exs. 1, 2, 19-1), and combined with his compensable injury to cause his recent low back disability, (see Ex. 27), claimant bears the additional burden of proving that his compensable injury is and remains the major contributing cause of the claimed disability and treatment. See ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991).

Based on the medical evidence, which is uncontradicted concerning causation, we find that claimant has carried his burden with regard to his disability and treatment following the February 28, 1990 work incident, until April 18, 1990. (See Ex. 17-1). However, Dr. Freeman, neurosurgeon, reviewed claimant's April 18, 1990 CT scan results and opined that the "apparent bulging of disc L5-S1 [is] consistent with [claimant's] history over the last years of increasing back pain to present difficulties necessitating myelogram and CT scan as recently done." (Ex. 27, emphasis added). Inasmuch as Dr. Freeman relied on the April 18, 1990, CT scan to relate claimant's then current low back condition to causes which preexisted the February 28, 1990 incident, and his opinion in this regard is uncontradicted, we conclude that claimant has not proven that his February 1990 work incident was the major contributing cause of his low back problems on and after April 18, 1990.

Compensability-aggravation claim

We adopt the Referee's opinion on this issue.

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 at hearing and on review concerning the February 28, 1990 low back injury issue is $1500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 19, 1991 is reversed in part and affirmed in part. That portion of the order that dismissed claimant's request for hearing is reversed and the request is reinstated. That portion of the order that upheld the insurer's denial of a "new injury" claim is reversed. That denial is set aside, and the claim is remanded for processing in accordance with this order. To the extent that the insurer's denial denied the compensability of claimant's current condition as of April 18, 1990, that portion of the denial is upheld. For services at hearing and on Board review concerning the compensability of the "new injury" claim and disability and treatment up to April 18, 1990, claimant's attorney is awarded an assessed fee of $1500, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CELESTE S. DEMETER, Claimant
WCB Case No. 91-02990
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The self-insured employer requests review of Referee Bethlahmy's order which set aside its denial of psychological treatment. On review, the issue is compensability. No respondent's brief has been filed by claimant. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

Claimant compensably injured her back. She began receiving compensable medical treatment from chiropractor Walter C. Trapp, who made inappropriate sexual and sexually suggestive remarks to claimant over a several-week period. Claimant developed an adjustment disorder with mixed emotional features. The major contributing cause of this condition was Dr. Trapp's behavior while he rendered treatment to claimant for her compensable condition.

Claimant does not contend that her original industrial injury directly resulted in this adjustment disorder. Rather, she contends that the adjustment disorder was an indirect or secondary consequence of her injury. We agree.

ORS 656.005(7)(a)(A) provides that for a consequential condition to be compensable, claimant must prove that the original compensable injury is the major contributing cause of the consequential condition.

In Julie K. Gasperino, 43 Van Natta 1151 (1991), we interpreted "consequential conditions" to be ones which are not intrinsically related to or a primary consequence of the original accident or injury itself.

The facts and the medical evidence support the Referee's conclusion that Dr. Trapp's conduct during the course of his treatment was the major contributing cause of claimant's consequential adjustment disorder. In fact, there is not evidence of any other contributing cause.

While claimant did not believe that Dr. Trapp's comments were intended as treatment themselves, they were clearly made while he was rendering treatment to her, and in at least one instance, he did touch her in a way that felt inappropriate as part of a treatment. That Dr. Trapp's behavior was with his mouth rather than with his hands does not break the chain of causation.

We affirm the Referee.

Inasmuch as no respondent's brief has been timely filed, no attorney fee under ORS 656.382(2) shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order of July 3, 1991 is affirmed.

March 5, 1992 Cite as 44 Van Natta 393 (1992)

In the Matter of the Compensation of
MARSHA K. FLANARY, Claimant
WCB Case No. 90-15238
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of those portions of Referee Peterson's order that: (1) set aside its denial of claimant's claim for her current low back condition; and (2) assessed a $2,500 attorney fee for claimant's counsel's services at hearing. Claimant cross-requests review of that portion of the Referee's order that found that the employer had not denied claimant's medical services claims for pain center treatment and a back corset. On review, the issues are compensability, attorney fees and medical services. We reverse in part, modify in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

The employer's denial denied claimant's "current treatment and conditions." The Referee concluded that the denial included claimant's previously accepted lumbar strain; he, therefore, set aside the denial in its entirety.

On review, the employer contends that, at hearing, it attempted to clarify the denial to include only claimant's degenerative disk disease and the proposed surgery. The employer asserts that it attempted to amend the denial itself in order to clarify the scope of the denial; however, the Referee interpreted the denial as applying to the previously accepted condition as well as the degenerative condition and surgery.

We agree that the Referee should have permitted the employer to amend its denial at hearing. Claimant's counsel agreed that "(a)mended, it might be cured...." (Tr. 7). However, claimant continued to assert that the original denial was the denial from which a hearing had been requested and claimant argued that the employer was actually "standing on their denial," at the time of hearing, regardless of the offer to amend. (Tr. 7, 9).

We conclude that, because claimant did not object to amendment of the denial and neither asserted surprise nor requested a continuance, amendment of the denial should have been permitted. See Lloyd L. Crockett, 43 Van Natta 1767 (1991); Donna J. Wilson, 42 Van Natta 1026 (1990). Accordingly, on review, we consider the denial, as amended, to deny only claimant's degenerative condition and surgery.

Compensability

It is claimant's burden to prove by a preponderance of the evidence that her accepted 1989 low back injury which combined with her preexisting degenerative joint disease is and remains the major contributing cause of her disability and need for treatment. ORS 656.005(7)(a)(B).

Here, claimant's treating physician, Dr. Misko, reported on August 13, 1990 that claimant had serious degenerative disc disease and pre-existing hypertrophic facets. Dr. Misko stated that he would not relate her need for surgery to her injury. Additionally, on August 27, 1990, Dr. Rosenbaum, reported that claimant's degenerative disc disease predated her October 22, 1989 injury and was not the "current maximum cause of her low back discomfort...." Dr. Rosenbaum also stated that claimant was not in need of further treatment.

We are persuaded that claimant's compensable 1989 injury is not the major cause of her disability and need for treatment. Accordingly, we conclude that her degenerative condition is not compensable. Moreover, we note that, although the employer contended that the denial included proposed surgery, the recommendation for surgery was withdrawn.

Assessed attorney fee

Although we have concluded that claimant's degenerative condition is not compensable and an attorney fee is not warranted for claimant's counsel's services on that issue, we nonetheless find that claimant is entitled to a reasonable assessed attorney fee for services concerning clarification of the denial. See Elaine Mitchell, 41 Van Natta 1798 (1989). Moreover, we have previously awarded insurer-paid attorney fees for clarifying inartfully-phrased or overbroad denials. See e.g. Mickey L. Wood, 40 Van Natta 1860 (1988).

In the present case, the employer's denial purported to deny only claimant's degenerative condition. However, the Referee found, and we agree, that the plain language of the written denial constituted a "blanket denial which covers everything including the already accepted lumbar strain." (O & O at 2). Thus, as we concluded in Mitchell, supra, claimant's condition was denied in toto, and she is entitled to an assessed attorney fee for services in prevailing over the denial insofar as it denied compensability of the lumbar strain

condition. See ORS 656.386(1). Accordingly, we modify the Referee's attorney fee award.

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 concerning clarification of the employer's denial is $750, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue and the value of the interest involved.

Medical services

Claimant contends that the Referee erred in determining that there were no "de facto" denials of requests for pain center treatment and use of a back corset. We agree with the Referee's alternative finding that the Hearings Division is without jurisdiction in this matter.

Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Here, we agree with the Referee's alternative finding that disputes such as this do not constitute matters concerning a claim. Accordingly, original jurisdiction lies exclusively with the Director. See Stanley Meyers, 43 Van Natta 2643 (1991). Furthermore, we have recently held that disputes regarding proposed medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992).

Inasmuch as the "de facto" denials did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate that portion of the Referee's order that purported to address the medical services issue and we dismiss claimant's request for hearing on the "de facto" denials of medical services. See Melvin L. Martin, 44 Van Natta 258 (1992).

ORDER

The Referee's order dated December 26, 1990 is reversed in part, modified in part and vacated in part. That portion of the Referee's order that set aside the self-insured employer's October 1, 1990 denial is reversed. The employer's denial, as amended at hearing, is reinstated and upheld. The Referee's assessed attorney fee award of $2,500 is modified. In lieu of the Referee's attorney fee award, claimant's counsel is awarded an assessed fee of $750, payable by the employer, for services concerning clarification of the employer's denial. That portion of the Referee's order that purported to address claimant's request for hearing on the employer's "de facto" denials of her medical services claims is vacated. Claimant's request for hearing on those denials is dismissed for lack of jurisdiction.

In the Matter of the Compensation of
DUNG D. HO, Claimant
WCB Case No. 90-15088
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Otto's order that: (1) directed it to pay claimant temporary total disability benefits beginning June 23, 1990; (2) assessed a penalty for an allegedly unreasonable termination of claimant's temporary disability benefits; and (3) awarded a penalty-related attorney fee and an assessed attorney fee for an allegedly unreasonable failure to process claimant's medical services claim for facet injections. In its brief, the insurer also disagrees with the Referee's assessment of a penalty based upon temporary disability benefits due through the date of hearing. On review, the issues are temporary total disability and penalties and attorney fees. We affirm in part, reverse in part, and vacate in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Senate Bill 1197. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Senate Bill 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Temporary total disability

We adopt the Referee's conclusions and opinion on the issue of temporary disability, with the exception of his last paragraph in that section. The insurer is directed to process claimant's claim for temporary disability benefits, beginning June 23, 1990, until such benefits may be terminated according to law.

Penalties and attorney fees

Unreasonable termination of temporary disability

The Referee concluded that the insurer unreasonably terminated claimant's temporary disability benefits. We disagree.

Here, although the insurer received Dr. Flemming's chart note indicating that claimant may have to travel to Vietnam, the insurer also had information from claimant's friend that claimant was in California visiting his brother. In addition, the insurer's claims examiner sent a certified letter to claimant informing him that if he did not respond by June 22, his claim would be submitted for closure. A second certified letter informed claimant that his benefits could be terminated if he did not report for the offered job on June 25. The

receipt for the certified letter was returned with claimant's name signed upon it.

Under the circumstances, we conclude that the insurer's termination of time loss benefits was not unreasonable. In addition, we find this case to be distinguishable from Juanita Allen, 42 Van Natta 1627 (1990), in which the insurer was charged with the employer's knowledge that claimant had been called away on a family emergency. In Juanita Allen, supra, we affirmed the Referee's conclusion that the claimant did not refuse a job offer when she advised her employer that she could not report to work as scheduled, due to the family emergency. In Allen, we concluded that the insurer unreasonably terminated temporary disability benefits because it knew that claimant had been called away on an emergency.

In the present case, however, the insurer had conflicting reports of claimant's whereabouts. Claimant did not notify the insurer that he was going to be out of the country for an extended period of time. Moreover, the insurer had receipts from certified letters which had claimant's name signed upon them during the time period that claimant was in Vietnam. Accordingly, we agree with the insurer that it had a legitimate doubt as to its liability for claimant's temporary disability payments. We therefore reverse the Referee on the issue of penalties and attorney fees for an allegedly unreasonable termination of temporary disability benefits.

Unreasonable medical services denial

The Referee initially determined that he had jurisdiction over the matter of claimant's request for facet injections. The Referee awarded claimant's counsel an assessed attorney fee of $300 for overturning the insurer's allegedly unreasonable "de facto" denial of facet injections. On reconsideration, the Referee also awarded claimant's counsel an assessed attorney fee of $1,400 for his services in setting aside the insurer's "de facto" denial of facet injections.

We conclude that the Referee did not have jurisdiction over this matter. The Referee found that ORS 656.327 did not apply because the facet injections were proposed treatments, rather than treatments claimant was "receiving", that were excessive, inappropriate or ineffectual as provided in ORS 656.327(1)(a). We disagree.

In the present case, the insurer contended that claimant's proposed facet injections were inappropriate. Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Subsequent to the Referee's order, we concluded that original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See Stanley Meyers, supra. Furthermore, we have recently held that disputes regarding proposed medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992).

Inasmuch as the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate that portion of the Referee's order that set aside the insurer's "de facto" denial of claimant's proposed facet injections and we dismiss claimant's hearing request on that issue.

We also vacate the Referee's penalty-related attorney fee award of $300 for claimant's counsel's services in setting aside the "de facto" denial of the proposed facet injections. Furthermore, we note that, on reconsideration, the Referee assessed an additional attorney fee of $1,400 for claimant's counsel's services on the issue of the facet injections. In light of our decision on the medical services issue, we also vacate the Referee's assessed attorney fee award.

For successfully defending against the insurer's appeal on the issue of temporary total disability, claimant's counsel is entitled to an assessed attorney fee. 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 issue of temporary disability is $600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 21, 1990, as reconsidered January 29, 1991, is affirmed in part, reversed in part and vacated in part. That portion of the Referee's order that awarded claimant a penalty for an allegedly unreasonable termination of temporary total disability benefits is reversed. The Referee's penalty-related attorney fee award is also reversed. That portion of the Referee's order that set aside the insurer's "de facto" denial of claimant's proposed facet injections is vacated. The Referee's penalty-related attorney fee award of $300, and his assessed attorney fee award of $1,400 for claimant's counsel's services on the facet injection issue are also vacated. Claimant's hearing request on the denial of medical services is dismissed for lack of jurisdiction. The remainder of the Referee's order is affirmed. For services on Board review concerning the issue of temporary disability benefits, claimant's counsel is awarded a reasonable attorney fee of $600, payable directly to claimant's counsel by the insurer.

March 5, 1992 Cite as 44 Van Natta 398 (1992)

In the Matter of the Compensation of
DORIS J. MATTIS, Claimant
WCB Case No. 90-19748
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kevin Mannix, PC, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Baker's order that upheld the self-insured employer's denial of claimant's occupational disease claim for an upper extremity condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant has worked in the employer's manufacturing plant since May 1989. Her job required repetitive motions with both hands and arms. She developed hand numbness and wrist pain after several months of work and purchased wrist splints for work. Her symptoms continued and, in August 1990, she consulted Dr. Herscher, who diagnosed possible carpal tunnel syndrome and referred her to Dr. Daven, a neurologist. Dr. Daven noted functional overlay and recommended nerve conduction studies, which were within normal limits.

On September 17, 1990, claimant was examined by Dr. Baskin, who diagnosed left and right wrist strain and possible early carpal tunnel syndrome. The same day, she was examined by Dr. Leibold, her family doctor, who diagnosed tendonitis in both shoulders and arms with synovitis and myofascitis.

Meanwhile, on September 14, 1990, the employer notified claimant that it was unable to accept responsibility for any treatment or disability relating to her current condition, asserting that the condition did not arise out of and in the course of employment. Claimant timely requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to establish a compensable claim for an occupational disease under ORS 656.802. The Referee based his decision, in part, on the lack of objective findings that her work was the major contributing cause of her disability or need for treatment. On review, we first agree with claimant that she established her upper extremity condition with medical evidence supported by objective findings.

ORS 656.802(2) provides that the "[e]xistence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings." We have construed "objective findings" as being satisfied if claimant offers evidence that a physician has examined her and determined that she suffers from a disability or a physical condition that requires medical services. See Suzanne Robertson, 43 Van Natta 1505 (1991); Catherine L. Martin, 43 Van Natta 2762 (1991) (applying Suzanne Robertson to occupational disease claims). That determination may be based on purely objective factors, ORS 656.005(19), or on the worker's description of the pain that she is experiencing, as long as the physician indicates that the worker in fact experiences symptoms and does not merely recite the worker's complaints of pain. Suzanne Robertson, supra.

In this case, Dr. Leibold found range of motion deficits, comparative strength deficits and tenderness on palpation. Dr. Daven noted tenderness with tapping of the left elbow, and Dr. Baskin found paresthesia in claimant's fingers with Phalen's test. Those reports clearly indicate that claimant, in fact, experienced the symptoms for which she was seeking treatment, thus satisfying the "objective findings" test, under Suzanne Robertson, supra.

Nonetheless, we agree with the Referee's ultimate conclusion that claimant had failed to establish a compensable claim. ORS 656.802(2) further provides that the "worker must prove that employment conditions were the major contributing cause of the disease or its worsening." We find that the causation of claimant's upper extremity condition is of sufficient medical complexity that we cannot resolve it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Claimant relies on the opinion of Dr. Leibold, who diagnosed the condition as tendonitis and post traumatic fibromyositis related to claimant's work

activities with the employer. However, his opinion is conclusory, because it offers no explanation how the condition resulted from her work activities. Accordingly, we do not find it persuasive and accord it little weight. Moe v. Ceiling Systems, 44 Or App 429 (1980).

We rely, instead, on the thorough and well-reasoned opinion of Dr. Herscher. Somers v. SAIF, 77 Or App 259 (1986). At his deposition, Herscher explained that repetitive work activities could produce upper extremity symptoms. However, he further explained that such symptoms would resolve shortly after the termination of such activities, especially if treated with anti-inflammatories and heat. Because claimant's symptoms did not resolve under such circumstances, and in light of the relatively minor objective findings compared to the severity of subjective complaints, he did not believe that her work could be the major contributing cause of her condition. We find his opinion persuasive evidence that claimant's condition is not work related in major part.

We agree with claimant that she is not required to prove a specific diagnosis to establish a compensable claim. However, the several doctors who examined her offered actual or tentative diagnoses based primarily on her subjective complaints, essentially unsubstantiated or uncorrelated with the objective "findings" they did note. Concerns were also expressed that non-work factors might be influencing claimant's experience of symptoms. In light of these factors, and the others noted by the Referee, we also conclude that, on this record, claimant has failed to establish by a preponderance of the evidence that her work activities were the major contributing cause of any upper extremity condition. Accordingly, claimant has failed to establish a compensable claim.

ORDER

The Referee's order dated April 23, 1991 is affirmed.

March 5, 1992 Cite as 44 Van Natta 400 (1992)

In the Matter of the Compensation of
JAMES J. SHEETS, Claimant
WCB Case No. 90-10325
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Menashe's order that decreased claimant's unscheduled permanent disability award from 22 percent (70.4 degrees), as awarded by a Determination Order, to 16 percent (51.2 degrees). On review, the issue is extent of unscheduled permanent disability.

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

Claimant contends that the Referee erred in reducing claimant's award of unscheduled permanent disability. Furthermore, claimant asserts that he is entitled to an increased award, totaling 45 to 55 percent. Specifically, claimant first maintains that his adaptability factor falls under former OAR 436-35-310(4), rather than former OAR 436-35-310(3), as the Referee determined.

The Referee correctly found that claimant returned to modified work, even though that seasonal job was of limited duration. See e.g. Joyce M. Ramirez-

Jones, 43 Van Natta 342, 343-44 (1991) (claimant's adaptability was properly determined under former OAR 436-35-310(3) because claimant returned to modified work as a seasonal employee). Former OAR 436-35-310(3) therefore is the appropriate rule for determining adaptability.

To assert his next three arguments, claimant relies on brief statements by his treating doctor that claimant has limited function of his right arm. First, claimant contends that he is entitled to an additional 5 percent award for a chronic condition limiting repetitive use of his right shoulder. See OAR 436-35-320(4). As stated above, however, the medical evidence cites only to a chronic condition limiting repetitive use of his right arm for which claimant received an award. As the Referee determined, there is no medical evidence to support a finding that claimant suffers from a chronic condition in his right shoulder.

Second, claimant asserts that this evidence showed by clear and convincing proof that the standards do not adequately reflect the degree of disability suffered by claimant. We disagree. We conclude that the Referee's award of 16 percent unscheduled permanent disability adequately compensates claimant for his disability.

Finally, claimant asserts that this evidence shows that he is entitled to either 192 degrees or 150 degrees scheduled permanent disability under ORS 656.214(2). We conclude that the Referee correctly relied on evidence that rated the impairment to claimant's right arm, rather than relying upon the brief statements of his treating physician.

As a final matter, we agree with the Referee that any ruling in this case on whether then-unpaid scheduled permanent disability benefits should be paid at $305 per degree would be premature and advisory in nature. Furthermore, we declare claimant's request to remand this matter for reopening of the record because this processing issue has arisen after the Referee's order and can be appropriately addressed through another proceeding.

ORDER

The Referee's order dated April 22, 1991, as amended May 17, 1991, is affirmed.

March 5, 1992 Cite as 44 Van Natta 401 (1992)

In the Matter of the Compensation of
ROBERT J. SWALES, Claimant
WCB Case No. 91-01114
ORDER ON REVIEW
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant, pro se, requests review of Referee's Leahy's order which upheld the self-insured employer's partial denial of his claim for his current mid and low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSION OF LAW AND OPINION

The Referee concluded that claimant's accepted strain is not the major contributing cause of the subsequent changes in his preexisting arthritic condition. Accordingly, the Referee upheld the employer's partial denial of claimant's current mid and low back condition requiring medical services. We agree.

Claimant has a preexisting arthritic condition. Therefore, although claimant has proven that there was a compensable injury on October 29, 1986, to obtain compensation for his current mid and low back condition claimant must, under ORS 656.005(7)(a)(B), also prove by a preponderance of the evidence that the compensable October 1986 injury is the major contributing cause of his disability or need for medical services. Bahman M. Nazari, 43 Van Natta 2368 (1991). We find that the causation of claimant's current mid and low back condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant seeks medical services directed toward his current back condition. However, between 1987 and 1990, claimant did not seek medical treatment for his back. In September 1990, claimant sought medical treatment with Dr. Gambler, orthopedic physician. (Ex. 59). Dr. Gambler diagnosed: "LS sprain with underlying arthritic changes." Dr. Gambler did not address causation at that time. (Id). In December 1990, Dr. Gambler reexamined claimant and diagnosed: "Persistent back pain and disability, source of which is unknown." (Ex. 62-2). In an April 5, 1991 letter in response to inquiries made by the employer's attorney, Dr. Gambler reported:

> " . . . I have reviewed the enclosed medical records. I do not believe I had seen all of these records previously. The information contained, particularly about the course of [claimant] in the earlier years, after his 1986 injury did seem to be new. This information suggests to me that his more recent complaints are not related to the 1986 injury.
>
> " . . . The conditions I referred to are those which [claimant] reported to me when I initially saw him in 1990. In view of the additional information, I do not feel it is medically probable that his more recent complaints are related to the 1986 injury described as in the lower thoracic back paraspinal musculature." (Ex. 68).

There is no contrary medical evidence.

Under these circumstances, we conclude that the medical evidence does not establish by a preponderance of the evidence that the October 29, 1986 injury is the major contributing cause of claimant's current mid and low back condition. Therefore, although claimant has established an occurrence of a compensable injury on October 29, 1986, his claim for current medical treatment and/or disability is not compensable. Accordingly, we affirm the Referee's order upholding the employer's partial denial.

ORDER

The Referee's order dated May 9, 1991 is affirmed.

In the Matter of the Compensation of
CHARLES D. GARDNER, Claimant
WCB Case No. 90-15446
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Peterson's order which set aside its back-up denial of claimant's low back injury claim. Claimant cross-requests review of that portion of the order which declined to award a penalty for an allegedly unreasonable back-up denial. Claimant also contends that SAIF is precluded by res judicata from issuing a back-up denial. On review, the issues are res judicata, the propriety of the back-up denial, compensability, and penalties. We reverse.

FINDINGS OF FACT

In January 1985, claimant first applied for unemployment compensation benefits. (Ex. 1-1). Beginning on February 28, 1985 through September 11, 1985, claimant received unemployment compensation benefits. (Ex. 2). On March 10, 1985, claimant filed for unemployment compensation for the first two weeks of March 1985, stating that he did not work during that time period. (Ex. 1-6).

On March 12, 1985, claimant went to the emergency room. The report states that claimant felt back pain when he was pulling on a fifth wheel pin at work. (Ex. 3). Claimant was diagnosed with low back muscle strain. (Id).

On March 13, 1985, claimant filed an 801 form, stating that he had injured his back at work on March 10, 1985, while pulling a pin from a fifth wheel. (Ex. 4). The form was signed by an officer of the employer and indicated that claimant had worked for the employer for two years. (Id).

SAIF accepted the workers' compensation claim. Claimant did not inform SAIF that he was receiving unemployment compensation benefits.

On June 7, 1990, a hearing was held regarding the rate of claimant's temporary disability benefits. Just prior to the hearing, SAIF discovered documents indicating that claimant had received unemployment compensation benefits during March 1985. The Referee offset any future permanent partial disability award to claimant in an amount equal to claimant's unemployment compensation benefits. (Ex. 6-2).

On June 19, 1990, SAIF withdrew its acceptance and denied the claim. (Ex. 5A-1). On January 10, 1991, a hearing was held regarding the issuance of the back-up denial.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

Claimant contends that, because SAIF was in possession of claimant's unemployment records at the time of the June 7, 1990 hearing regarding claimant's temporary disability rate, SAIF "waived" its right to assert its "Bauman defense." We understand claimant to be arguing that, because SAIF was aware of claimant's unemployment records and it failed to raise the relevance of those records with regard to the compensability of the claim at the time of the earlier hearing, res judicata precludes it from issuing a back-up denial.

We reject claimant's contention. The June 7, 1990 hearing concerned claimant's entitlement to temporary disability. SAIF did not issue its back-up denial until June 19, 1990. Until SAIF issued the back-up denial, no justiciable controversy existed between the parties concerning the back-up denial. Moreover, it was not until claimant testified at the June 7, 1990 hearing that SAIF concluded that claimant had acted fraudulently. Therefore, this issue was not actually litigated or "raisable" at the time of the earlier hearing. See Drews v. EBI Companies, 310 Or 134, 142-43 (1990). We therefore proceed to address the merits of the back-up denial.

Propriety of the back-up denial

Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch. 2, 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

Although the Referee found that claimant was fraudulent regarding his unemployment compensation claim, he concluded that "there is no evidence that he made any misrepresentations regarding his workers' compensation claim." The Referee therefore set aside SAIF's back-up denial, determining that SAIF failed to prove that it accepted the claim based upon a material misrepresentation or fraud by claimant.

SAIF challenges the Referee's conclusion. It argues, first, that the principles enunciated in Bauman v. SAIF, 295 Or 788 (1983), continue to apply under the amended statutes pertaining to back-up denials, and, second, that it satisfied its burden of proof necessary to uphold its back-up denial.

ORS 656.262(6) provides:

> "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable * * *, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial."

We recently construed this statute in Anthony G. Ford, 44 Van Natta 240 (1992). We held that the statute evidenced an intent to overturn the Bauman rule to the extent that an insurer need not prove fraud, misrepresentation or other illegal activity to uphold a back-up denial issued within two years of claim acceptance. After reviewing the legislative history, however, we further held that the legislature did not intend to prohibit denials of fraudulent claims more than two years after claim acceptance. Accordingly, an insurer's back-up denial issued more than two years after claim acceptance is permissible so long as it is supported by a showing of fraud, misrepresentation or other illegal activity.

In this case, SAIF initially accepted the claim in 1985 and issued the back-up denial in June 1990. Therefore, because the back-up denial was issued more than two years after claim acceptance, SAIF must prove fraud, misrepresentation or other illegal activity that was sufficiently material that the insurer's decision to accept the claim could reasonably have been affected. See Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987).

SAIF's acceptance was for an injury to claimant that occurred on March 10, 1985. SAIF proved, however, that claimant had filed for, and was receiving, unemployment compensation benefits from February 1985 through September 1985. SAIF contends that these facts show that claimant either lied in connection with

his unemployment compensation, by asserting that he was not working during the time he received such benefits, or in connection with his workers' compensation, by asserting that he was injured during a period of time that he was not working. SAIF maintains that it therefore demonstrated that claimant committed fraud and that its back-up denial is therefore valid.

We agree that claimant committed fraud. We also conclude that claimant's fraud was sufficiently material that SAIF's decision to accept the claim could reasonably have been affected. The fact that claimant was collecting unemployment compensation benefits during March 1985, and signed a form stating that he was not working during that time, raises a question as to whether claimant was employed at the time that he allegedly was injured. This issue would be of great significance in determining whether to accept the claim. We therefore find that SAIF's back-up denial is procedurally valid and, therefore, we address the compensability issue.

Compensability

Claimant contends that he was injured at work on March 10, 1985, while pulling a fifth wheel pin. At the February 27, 1991 hearing, claimant's wife testified that she picked claimant up after work on that date and observed him having trouble getting into the car due to back pain. (Tr. 73-75). She further testified that the next day claimant was in such pain that she took him to the hospital and called to inform his employer that claimant was not able to work. (Id. at 77). Claimant did not testify at this hearing on advice of counsel.

The documentary evidence, however, fails to support claimant's wife's testimony. First, the hospital records show that claimant went to the hospital on March 12, 1985 rather than March 11, 1985. (Ex. 3). The report also states that, "at work yesterday, [claimant] was pulling on a 5th wheel pin, and had onset of low back pain," id., indicating that claimant told hospital personnel that he was injured on March 11, not March 10.

Moreover, the 801 form filed by claimant states that "worker advised us the following morning that he was having some back problems," (Ex. 4), as opposed to claimant's wife's testimony that she informed the employer about claimant's injury. The 801 form also demonstrates that the employer doubted the validity of the claim, stating that "no one around when this happened--nothing said until following morning." (Id.) Like the employer, we note that, although claimant reported on the 801 form that he was injured at 9:00 a.m. and his wife testified that he obviously was in pain, he did not report the incident to the employer until the next day.

There are also reasons for doubting claimant's credibility. Of foremost significance is claimant's fraudulence in obtaining unemployment compensation benefits. Although there is evidence that claimant had been working for the employer for two years as of March 1985, (see Ex. 4), claimant began receiving unemployment compensation in February 1985 and continued receiving such benefits through September 1985. While testifying at the June 7, 1990 hearing, claimant was unable to recall having applied for unemployment compensation in 1985, causing the Referee to state that "claimant's credibility is seriously in question[.]" (Ex. 6-2). Moreover, claimant, at the June 7, 1990 hearing, and his wife, at the January 10, 1991 hearing, refused to answer questions regarding their 1985 federal income tax return on the basis that their answers could be incriminating.

In short, based on the lack of corroboration by the evidence that claimant was injured on March 10, 1985, in combination with evidence regarding claimant's

lack of credibility, we are not persuaded that claimant's injury claim is compensable. We therefore uphold SAIF's back-up denial.

Penalty

Having concluded that SAIF was entitled under Bauman to issue the back-up denial, and the back-up denial was valid because claimant failed to prove compensability, we need not address claimant's contention that SAIF's issuance of the back-up denial was unreasonable.

ORDER

The Referee's order dated February 13, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's award of $2,000 to claimant's attorney is reversed.

March 6, 1992 Cite as 44 Van Natta 406 (1992)

In the Matter of the Compensation of
BENINO T. ORN, Claimant
WCB Case No. 90-13662
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of Referee Bethlahmy's order which upheld the insurer's denial of claimant's injury/occupational disease claim for his low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the last finding. Instead, we find that claimant's work in March 1990 was the major contributing cause of his current low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant did not sustain a new injury at work during March 1990 because claimant's increased pain was not tied to any specific incident at work. The Referee further concluded that claimant failed to establish that work was the major contributing cause of his disability and need for medical treatment. We disagree.

Because a hearing was convened after July 1, 1990, we analyze this claim under the 1990 revisions to the Workers' Compensation Law. See Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant asserts that he sustained either a new compensable injury or an occupational disease during the last week of March 1990 which resulted in his current low back condition. The issue of compensability of claimant's current low back condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of the 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).

In order to prove a new compensable injury, claimant must establish that the March 1990 injury was at least a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The injury

must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a); 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

However, in cases involving preexisting conditions, we have recently held that whether a claim is compensable is a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that he suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of her disability or need for medical treatment. See ORS 656.005(7)(a); Mark N. Wiedle, supra. Claimant's disability or need for medical treatment must be established by medical evidence supported by objective findings. See Suzanne Robertson, supra. Then, if it is determined that there is a preexisting condition and that the condition combined with the injury to cause or prolong disability or need for treatment, claimant is entitled to disability compensation and treatment only if the injury was the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B).

Alternatively, claimant may establish compensability of his condition as an occupational disease by proving that employment conditions were the major contributing cause of the disease or its worsening. The existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

We conclude that, under either theory of compensability, claimant has established a compensable causal relationship between his work activities and his low back condition. We base this conclusion on the following reasoning.

The key medical opinion, and the one on which claimant relies, is that of Dr. Nash, claimant's treating neurosurgeon. After examining the claimant on May 14, 1990 (Ex. 41) and reviewing radiology studies done on April 5, 1990 and May 21, 1990 (see Exs. 39, 42), Dr. Nash diagnosed "lumbar radiculopathy S1 left due to disc prolapse." (Ex. 52). It is Dr. Nash's opinion that claimant's work during the latter part of March 1990 was the main cause of claimant's current back condition, explaining that "[h]ad he had a disk problem prior to 1990, he would not have been able to follow that work assignment. So I believe that acute worsening did occur in March of 1990, based on history and his compromised ability to work and the neurologic finding, as previously referenced." (Ex. 57-18). Dr. Nash explained that the degenerative changes revealed in claimant's 1990 radiology studies, which are clustered at a single level, are due to some event or change occurring at that level, not to a generalized "aging process." (Ex. 57-8). Finally, Dr. Nash endorsed his earlier opinion regarding the etiology of claimant's current back condition (Ex. 57-19 to 57-20):

"Based upon the fact that this patient has never prior to my examination had the diagnosis of a disc prolapse substantiated, and based upon the fact that subsequent to December 1988 there was a distinct worsening of his condition which would ultimately diagnose as listed above, [lumbar radiculopathy S1 left due to disc prolapse], it is my opinion that the work in which the patient was engaged in and terminated on March 20, 1990 [sic], was definitely aggravational and did result in the diagnosis in the disc prolapse diagnosis now established." (Ex. 52).

There is no contrary medical opinion in the record. However, the insurer argues that we should not rely on Dr. Nash's opinion because Dr. Nash did not have access to claimant's past medical records. We are not persuaded by insurer's argument. Dr. Nash had a substantially complete and consistent medical history from claimant on which he relied in forming his opinion (see Ex. 41). Dr. Nash reviewed claimant's previous medical records during his deposition, and was aware of the results of the 1984 CT scan (Ex. 27), earlier radiology reports

(Exs. 6, 12), and the fact that claimant has an award of 30 percent permanent disability on his back (Ex. 57-12). (See Ex. 57-15 to 57-16). He was also aware that claimant likely experienced some leg pain associated with his initial injury (Ex. 57-13). Nevertheless, he concluded that claimant's work in March 1990 was the main and independent cause of claimant's current back condition (Ex. 57-18), and he endorsed his previous opinion (Ex. 57-19 to 57-20). Accordingly, we find no persuasive reason not to rely on Dr. Nash's opinion.

The insurer contends that Dr. Nash's opinion should be disregarded because his opinion relies in part on the appearance of left leg pain in March 1990 (Ex. 52) and claimant's "categorical" denial of any previous leg pain (Ex. 57-6). The insurer points to evidence of earlier leg pain in the following medical records: an emergency room chart note from Tuality Community Hospital dated December 4, 1982 (Ex. 3), a medical report from a neurosurgical consultation by Dr. Silver dated January 12, 1983 (Ex. 5-2), a chart note by Dr. Silver dated February 2, 1983 (Ex. 9), and a second medical report by Dr. Silver dated July 19, 1984 (Ex. 24-2).

After reviewing the record, we conclude that evidence of earlier leg pain is not inconsistent with Dr. Nash's opinion concerning claimant's current back condition. Following claimant's original back injury in 1982, the medical records reveal that claimant had some diminished sensation over the back of the left leg (Ex. 5-2), but no pain radiating into the left leg (Exs. 3, 5-1). In 1983 and 1984, claimant experienced occasional pain radiating to the posterior aspect of his left leg and heel, associated with severe back pain. (Exs. 9, 24-2). However, at that time a herniated disc was not established (Ex. 27). After 1984, when claimant began working for the employer, there is no evidence of continuing or even episodic leg pain until March 1990 (see e.g., Ex. 32-1). In March 1990, Dr. Noyes, claimant's regular treating doctor, initially examined him and reported left leg pain down to the sole of the foot (Ex. 40-1), and claimant complained of shooting pain into his left leg and foot (Ex. 45-2). Under these circumstances, we conclude that any discrepancy concerning the presence of prior leg pain does not undermine the persuasiveness of Dr. Nash's opinion.

Accordingly, we rely on the reports and expert medical opinion of Dr. Nash and find that claimant has established that work activities were the major contributing cause of claimant's current back condition. We further find that Dr. Nash's report and the radiology studies on which he relies (see Exs. 39, 41-3, 42 and 52) constitute medical evidence supported by objective findings that establish the existence of claimant's current low back condition.

Under such circumstances, we conclude that claimant has established the compensability of his current low back condition.

Claimant is entitled to an assessed attorney fee for his counsel's services at hearing and on review concerning the compensability issue. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $3,000 is a reasonable fee, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's opening and reply briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel's efforts might go uncompensated.

ORDER

The Referee's order dated March 25, 1991 is reversed. The insurer's denial is set aside, and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $3,000, payable by the insurer.

In the Matter of the Compensation of
JAMES L. ORTIZ, Claimant
WCB Case Nos. 91-01054 & 90-18519
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
John M. Pitcher, Defense Attorney

Reviewed by Board Members Moller and Tenenbaum.

Claimant requests review of Referee Brazeau's order that: (1) upheld the self-insured employer's denial of his claim for a neck and upper back injury; (2) upheld the employer's denial of his aggravation claim for his current back condition; and (3) declined to award a penalty and related attorney fee for an allegedly unreasonable denial. The employer moves to supplement the hearings record. We treat the motion as a request for remand. On review, the issues are remand, compensability, aggravation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions of Law and Opinion, with the following supplementation.

Remand

On review, the employer moves to supplement the record to reflect the fact that claimant did not appear personally at hearing, yet claimant's counsel had contact with his client during the course of the hearing. We treat the employer's motion as a request for remand.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser, 301 Or 641 (1986).

Claimant's counsel appeared at hearing. Claimant was entitled to offer the remainder of his evidence, even if he chose not to testify personally. See Williams v. SAIF, 99 Or App 367 (1989). Accordingly, we do not find that the record has been improperly, incompletely or otherwise insufficiently developed. Accordingly, the employer's request for remand is denied.

ORDER

The Referee's order dated May 21, 1991 is affirmed.

In the Matter of the Compensation of
MICHAEL J. QUINLAN, Claimant
WCB Case No. 91-03179
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Otto's order that found that he was precluded by the doctrine of res judicata from requesting reclosure of his wrist and back claim. On review, the issue is res judicata.

We affirm and adopt the Referee's order, except for the final sentence of his "Findings of Ultimate Fact," with the following supplementation.

As a preliminary matter, we note that on December 26, 1991, the Board affirmed and adopted Referee Neal's March 11, 1990 order in WCB Case No. 90-22129.

Claimant contends that the Board should conclude that res judicata does not bar reclosure of claimant's claim, based on the holding of Calkins v. Westcraft Chair, Inc., 84 Or App 320 (1987). We disagree.

The facts in Calkins are distinguishable from the present case. In Calkins, the claimant complained of hip pain to her employer, attributing it to her work activities. However, she did not file a claim for a hip problem at that time. Subsequently, she was injured when a furniture frame fell on her. The claimant's description of the incident depicted a low back and neck injury. She received treatment for her low back, neck and hip.

At hearing, the claimant alleged a de facto denial of her low back/hip condition and the Referee dismissed claimant's claim. The Board affirmed without opinion. The claimant then filed a specific claim for her hip condition. The Referee held that claimant was barred by res judicata, stating that the same issue had been litigated at the prior hearing. The Board affirmed without opinion. The Court of Appeals reversed, holding that claimant was not barred by the doctrine of res judicata since her hip claim was a separate claim which did not involve the same operative facts. Calkins, supra.

In the present case, however, claimant fell from a ladder and compensably fractured his wrist and two vertebrae in his back. The medical evidence establishes that both injuries were caused by the same fall. (Ex. 50). Claimant filed a claim for his wrist and back injury. (Exs. 1, 36, 46). Claimant did not attribute his back condition to any other on-the-job incident or work activity.

We find that, unlike the claimant in Calkins, claimant's wrist and back conditions did not involve two separate claims. The fact that the claimant in Calkins was treated for both his hip injury and his injuries sustained in the furniture frame incident are irrelevant to the present case. Here, both of claimant's conditions arose out of the same work incident and involve the same facts. Claimant's claim was processed to closure with an award for claimant's back condition in addition to his wrist condition. Claimant waived his right to challenge that award and received the award in a lump sum.

Under the circumstances, we agree with the Referee that claimant's request is barred by the doctrine of res judicata.

ORDER

The Referee's order dated June 18, 1991 is affirmed.

In the Matter of the Compensation of
MARILYN M. JENSEN, Claimant
WCB Case No. 90-17184
ORDER ON REVIEW
Dwayne R. Murray, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The self-insured employer requests review of that portion of Referee Brown's order that set aside its denial of claimant's occupational disease claim for a left ulnar neuropathy. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant has worked in the employer's mill for approximately ten years. During the past three years, she worked as a synthetic route line operator, which involves the operation of a variety of hand held tools used to fill defects on plywood panels. The work requires frequent gripping with both hands and repetitive elbow flexion.

In 1987, claimant began to experience numbness in two fingers on her left hand and pain in her left wrist. By 1989, she also experienced pain and occasional numbness in the right thumb and infrequent tingling and numbness in the fingers of her right hand. She sought treatment from Dr. Helman, who diagnosed a left ulnar nerve irritation and tenosynovitis of the right thumb.

In May 1990, claimant was examined by Dr. Corson, who obtained x-rays that revealed basilar arthritis in the right thumb. Corson indicated that surgery would be required for both the right thumb and left ulnar nerve palsy and placed claimant on modified work.

On May 29, 1990, claimant filed a claim against the employer for the ulnar nerve problems in the left hand and problems with the right thumb joint.

In June 1990, claimant was examined by Dr. Grant, who diagnosed left ulnar neuropathy and bilateral carpal tunnel syndrome. At the employer's request, claimant was also examined by Dr. Nathan in August 1990. Nathan found abnormalities in both the right and left ulnar and median nerves and concluded that the entrapment neuropathies were unrelated to claimant's work activities.

On August 17, 1990, the employer issued a denial of claimant's bilateral carpal tunnel syndrome, left ulnar neuropathy and arthrosis of the right thumb, asserting that her work activities were not the major contributing cause of either the development of a worsening of the conditions. Claimant subsequently requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The employer seeks review of that portion of the Referee's order which held that claimant's left ulnar neuropathy is compensable as an occupational disease. We affirm.

In order to establish the compensability of an occupational disease under ORS 656.802(1)(c), claimant must prove that her work exposure involved a series of traumatic events that were the major contributing cause of the disease or its worsening. The existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. We find that the causation of claimant's left ulnar nerve condition is of

sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Three expert opinions on medical causation were submitted in this matter. Claimant relies on the opinions of Dr. Corson and Dr. Pons, both of whom concluded that claimant's work was the major contributing cause of the left ulnar neuropathy. The employer relies on the opinion of Dr. Nathan, who concluded that the major contributing cause of claimant's condition is the natural progression of an underlying disease process that had not been materially affected by her job activities.

When there is a dispute between medical experts, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1990). After our review of the opinions submitted in this matter, we find the opinion of Dr. Corson most persuasive and, accordingly, give it the most weight. He noted that, when an elbow is flexed, or bent, the distance that the ulnar nerve must travel around the posterior aspect of the elbow is greatly increased. He explained that such flexion causes a stretching or traction factor, which can cause an irritation of the ulnar nerve. Because claimant's work activities involve the repetitive flexing of the elbow, Dr. Corson concluded that, in the absence of any contrary evidence, the work was the major contributing cause of her condition. His opinion is supported by that of Dr. Pons, who agreed that her work was the contributing cause of the neuritis.

We give less weight to the opinion of Dr. Nathan, because he failed to adequately address the role of claimant's work activities involving the repetitive flexion of the elbow. He indicated that full elbow flexion compresses the ulnar nerve and that repetitive flexion could lead to an ulnar neuropathy. In rendering his opinion, however, he concentrated his analysis on claimant's hand activities, i.e., repetitive gripping, flexion of fingers to activate tools, and concluded that he "was unable to identify any pattern of hand activities in this job which would have resulted in the ulnar nerve lesions at the elbows[.]" (Ex. 28-4). (Emphasis supplied.) His narrow focus on claimant's hand activities is further demonstrated by his belief that the work might be a causative factor if the nerve lesions were located "in the ulnar two digits on the left [hand] and diffusely across the palm." (Ex. 28-5).

After our review, we find that claimant has established that her work activities was the major contributing cause of her left ulnar neuritis. Accordingly, we conclude that the condition is compensable as an occupational disease and affirm the Referee's decision.

As a final matter, we note that the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant. Under such circumstances, claimant's attorney would ordinarily be entitled to an attorney fee under ORS 656.382(2). Claimant's attorney, however, filed no brief on review. No fee, therefore, will be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated May 7, 1991 is affirmed.

In the Matter of the Compensation
VICKIE M. LIBEL, Claimant
WCB Case No. 91-01587
ORDER ON RECONSIDERATION
Gatti, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

On February 19, 1992, we modified a Referee's order that had awarded claimant 15 percent (48 degrees) unscheduled permanent disability for a low back and left hip injury. Specifically, we increased claimant's award to 18 percent (57.6 degrees).

In reaching our determination, we noted that the evaluation of a worker's disability shall be as of the date the Reconsideration Order was issued pursuant to ORS 656.268. However, we neglected to further state that, in performing that evaluation, the "time of determination" of a worker's disability, excluding permanent impairment, is made as of the date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8) (now section (12)) provides that the "[t]ime of determination is the mailing date of the Determination Order or Notice of Closure issued pursuant to ORS Chapter 656.268." Moreover, in rating adaptability, which is the only matter addressed in the present case, the administrative rules provide that the issue of whether a worker has returned to modified work is decided at the time of determination. Former OAR 436-35-310(3)(a).

In light of the aforementioned statutory and administrative requirements, we conclude that, in performing the evaluation of claimant's disability (excluding permanent impairment), her disability is determined as of the mailing date of the September 20, 1990 Determination Order. This alteration in our reasoning does not change our finding that claimant's adaptability value equals 2.5. Former OAR 436-35-310(3)(d). Inasmuch as claimant's adaptability value remains unchanged, we continue to conclude that her permanent disability award under the standards is 18 percent.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KAREN MANNING-ROBINSON, Claimant
WCB Case No. 91-01755
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Hoguet's order which set aside its denial of claimant's injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's injury arose out of and in the course of her employment. We disagree.

In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted a unitary "work-connection" approach for assessing if the relationship between claimant's injury and employment is sufficient to render an injury compensable. Id at 642.

Injuries sustained while going to or coming from work are generally not deemed to arise out of and in the course of employment. SAIF v. Reel, 303 Or 210 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). If an injury occurs in a parking lot or other off premises area over which the employer has no control, it is generally not compensable. Montgomery Ward v. Cutter, 64 Or App 759 (1983). Employer control is manifested either by employer ownership, employer actions or the presence of employer-created special hazards. Sheri V. Hiltner, 42 Van Natta 1039 (1990).

Here, claimant, a salesperson for a large retail store, fell in a parking lot in front of her employer's store. She slipped on ice while returning to her employer's premises during her unpaid lunch break. However, the employer does not own, lease or manage the parking lot.

This case is distinguishable from Montgomery Ward v. Malinen, 71 Or App 457 (1984). In Malinen, the claimant was returning to work from jury duty when she slipped on ice on the sidewalk in front of the employer's building. The city had a code requiring the employer to keep the sidewalk clear of snow and ice, and it was the employer's policy to do so. The court found that the "going and coming" rule did not bar compensation because the policy of removing snow and ice established employer control over the area of injury.

Here, it was not the employer's responsibility to maintain the parking lot or keep it clear from snow or ice. The employer requires employees to park in three rows at the far edge of the parking lot; however, there is no evidence to support a finding that the employer exercised control over the conditions of the parking lot. Actual control by the employer of the area of injury is necessary to establish control. Cope, supra; Janet V. Dollens, 42 Van Natta 2004 (1990). Accordingly, under the "going and coming" rule, we find that claimant was not within the course and scope of her employment when her injury occurred.

We also, in the alternative, apply the seven-factor test first set forth in Jordan v. Western Electric, 1 Or App 441 (1970). These factors are: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Id.

We agree with the Referee's conclusion that the employer was aware of, and anticipated, that claimant would take a lunch break. We also agree with the Referee that there was a benefit to claimant's employer in having its staff take a lunch break. See Sheri V. Hiltner, supra. However, since claimant was on an unpaid lunch break and was free to do whatever she wanted, her activity at the time of injury was not incidental to her employment with the employer. See Sheri V. Hiltner, supra.

We contrast the present case from the situation in Fred H. Jacobson, 43 Van Natta 1420 (1991), where because of the nature of the claimant's job, it was not feasible for him to take lunch breaks on his employer's premises. It was, therefore, an ordinary risk of the claimant's job in Jacobson to leave the employer's premises to eat in restaurants. By contrast, in the present case, the employer also provided an employee lounge with a refrigerator. Accordingly, it was feasible for claimant to eat lunch on the employer's premises, as she intended to do here after retrieving her lunch from her car. The only reason claimant did not bring her lunch inside with her when she first arrived at work was because she was rushing to arrive at work on time.

Generally, an accidental injury to an employee is not covered by workers' compensation as being one arising out of and in the course of employment if it occurs off the employer's premises while the employee is going to or coming from lunch on unpaid time. See Casper v. SAIF, 13 Or App 464 (1973). As discussed previously, we find that claimant's injury did not occur on the employer's premises or in an area over which the employer exercised control.

Claimant did not establish that she was paid during the time in which the injury occurred. Claimant was allowed an hour unpaid lunch. She had not returned to work at the time of her injury. We also agree with the Referee that claimant was clearly on a personal mission at the time of her injury.

Finally, the Referee concluded that the employer's designation of employee parking spaces created a special hazard for the employees. We disagree. Claimant's fall was attributed to ice. Claimant testified that the ice was no more or less near the store than away from it. (Tr. 22). The area in which she parked was not for the exclusive use of employees. Claimant was not required to drive to work. Under these circumstances, we do not find that claimant's risk of falling was "special" to her employment.

After considering all of these factors, we conclude that claimant's injury is not sufficiently related to her work activities to be compensable under the workers' compensation statutes. Therefore, we are not persuaded that claimant's injury arose out of or in the course and scope of her employment. In reaching this conclusion, we are persuaded by the fact that: (1) claimant was under no obligation to leave the premises for lunch; (2) her injury resulted from an act which was not an ordinary risk of, or incidental to, her employment; and (3) the injury did not occur on the employer's premises. See Jennifer J. Kahn, 43 Van Natta 2760 (1991).

Consequently, under the "going and coming" rule, as well as the seven factors set out in Mellis v. McEwen, Hanna, Gisvold, supra, claimant was not in the course and scope of her employment at the time of the injury. Accordingly, we conclude that the claim was not compensable.

ORDER

The Referee's order dated May 31, 1991 is reversed. The insurer's denial is reinstated and upheld. The Referee's $2,200 attorney fee is reversed.

In the Matter of the Compensation of
SANDIE K. DRIVER, Claimant
WCB Case No. 90-12482
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Emerson's order which awarded claimant 28 percent (42 degrees) scheduled permanent disability for a right forearm injury, whereas a Notice of Closure had not awarded any scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer contends that since no physician has measured claimant's grip strength or has attributed claimant's loss of grip strength to atrophy, anatomical changes, or nerve damage, claimant is not entitled to an award for loss of grip strength. We agree.

Loss of grip strength is ratable under the standards provided that the loss is attributable to nerve damage, atrophy, or other anatomical changes due to the compensable condition. Former OAR 436-35-110(3); Martha L. Brunner, 42 Van Natta 2587, 2589 (1990). The measurement of such a loss is required to be provided by a physician. Former OAR 436-35-005(1); Robert C. Killion, 42 Van Natta 2109, 2110 (1990).

Here, the Referee relied on a physical therapist's report to find that claimant had 25 percent impairment due to loss of grip strength under former OAR 436-35-110(3)(d). The record does not show that any physician measured claimant's grip strength or attributed any loss of grip strength to nerve damage, atrophy or other anatomical change due to claimant's compensable condition. Moreover, the record does not indicate that any physician adopted the physical therapist's findings. See Markus M. Tipler, 43 Van Natta 1968 (1991), (in which claimant's physician adopted the physical therapist's findings as his own). Consequently, we conclude that claimant is not entitled to an award for lost grip strength under former OAR 436-35-110.

The Referee's finding that claimant is entitled to a 2.5 percent award for loss of dorsiflexion of the right wrist is not disputed by the parties. Therefore, we adopt the Referee's 2.5 percent award for loss of dorsiflexion of the right wrist. This figure is rounded to 3 percent. Former OAR 436-35-010(6).

ORDER

The Referee's order dated May 30, 1991 as reconsidered June 27, 1991 is modified. In lieu of the Referee's award of 28 percent (42 degrees), for loss of use or function of the right forearm, claimant is awarded a total of 3 percent (4.5 degrees) scheduled permanent disability. Claimant's attorney fee award shall be modified in accordance with this reduction. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
RODNEY D. JACOBS, Claimant
WCB Case No. 90-13029
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee McWilliams' order which: (1) affirmed a Determination Order that found claimant medically stationary on April 4, 1990; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 24 percent (76.8 degrees), as awarded by Determination Order, to 26 percent (83.2 degrees). Alternatively, claimant requests remand for consideration of additional medical evidence. On review, the issues are medically stationary date, extent of unscheduled permanent disability and remand. We affirm the Referee's order and deny claimant's remand motion.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

The record closed following the October 31, 1990 hearing. The Referee's order issued on December 11, 1990. On January 4, 1991, claimant sought to have the record reopened in order to introduce additional medical evidence (another report from Dr. Gallo, claimant's treating surgeon, concerning her opinion as to the cause of claimant's bulging disc).

The Referee declined to reopen the record, finding that claimant failed to establish that Dr. Gallo's report was unavailable at the time of the hearing.

Dr. Gallo's medical report concerning claimant's disc bulge was obtainable at the time of the hearing with due diligence.

ULTIMATE FINDINGS OF FACT

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

The Referee was within her discretion in declining to reopen the record to admit additional medical evidence.

The record was not improperly, incompletely or otherwise insufficiently developed.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and opinion with regard to the issues of claimant's medically stationary date and the extent of claimant's unscheduled permanent disability. As to claimant's motion to remand his case to the Referee for admission of additional medical evidence, we deny the motion.

On review, claimant contends that the Referee erred in denying his motion to reopen the record to admit Dr. Gallo's medical opinion concerning the cause of his bulging disc and argues that, because of this error, the record was incompletely or otherwise insufficiently developed. We disagree.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS

656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). However, before we address claimant's remand motion, we first respond to his contention that the Referee erred in denying his motion to reopen the record for further evidence.

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. Renia Broyles, 42 Van Natta 1203 (1990). We review the Referee's evidentiary rulings for abuse of discretion. Id.

Here, claimant requested reopening of the record, almost a month after hearing and following issuance of the Referee's order. The request was made to permit the submission of a medical report by Dr. Gallo, which opined that claimant's 1987 compensable injury was "the material contributing cause of his bulging disc at the lumbosacral interspace." Claimant contended that he did not produce this evidence at hearing because he was under the impression that the symptoms and treatment relative to his bulging disc condition were not contested. We conclude that the Referee did not abuse her discretion in declining to reopen the record.

Claimant had the responsibility at hearing to affirmatively establish permanent impairment resulting from his bulging disc and also to substantiate a causal relationship between his disc bulge and his compensable injury. See ORS 656.214(5); Daniel G. Huff, 42 Van Natta 2805 (1990). Furthermore, there was evidence in the record that claimant did have a preexisting back condition (Ex. 10). Inasmuch as the burden of proving lost earning capacity resulting from the compensable injury was on claimant, he was required to be prepared to establish that his permanent impairment (including the disc bulge) was causally related to his compensable injury. Finally, the record already contains numerous reports by Dr. Gallo (see Exs. 12, 15, 16, 19, 22, 26, 31, 34 and 39). Under such circumstances, we hold that the Referee did not abuse her discretion in finding that the additional report claimant sought to introduce after the record closed could have been procured and produced at the time of the hearing with due diligence.

With regard to claimant's motion for remand, we are not persuaded, in light of the circumstances described above, that the medical evidence that claimant seeks to be introduced on remand, was unobtainable with due diligence at hearing. Therefore, we are likewise unpersuaded that the current record concerning the extent of claimant's unscheduled permanent disability is improperly, incompletely or otherwise insufficiently developed without that medical evidence. Accordingly, we deny claimant's remand motion.

ORDER

The Referee's order dated December 11, 1990, as amended and reconsidered April 29, 1991, is affirmed.

In the Matter of the Compensation of
BRIAN S. MODE, Claimant
WCB Case No. 90-10428
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Baker's order which: (1) set aside the insurer's denial of claimant's right elbow/ulnar nerve condition and resulting treatment; (2) set aside the insurer's denial of claimant's aggravation claim for the same condition; and (3) awarded claimant a $3,500 carrier-paid attorney fee. On review, the insurer contends that claimant's right elbow/ulnar nerve is not compensable and that the Referee's attorney fee award should be reduced.

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

The Referee found that claimant's right elbow/ulnar nerve condition was compensable. Consequently, the Referee set aside the insurer's denials of claimant's condition and aggravation claim for the condition. On review, the insurer contends that claimant's condition is not compensable because the medical evidence is not supported by objective findings. We disagree.

As a preliminary matter, we note that claimant requested a hearing in this case after May 1, 1990 and a hearing was convened after July 1, 1990. Therefore, we apply the 1990 statutory amendments. Or Laws 1990 (Special Session), ch. 2; see Ida M. Walker, 43 Van Natta 1402 (1991).

"Objective findings" include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings. ORS 656.005(19). As we stated in Suzanne Robertson, 43 Van Natta 1505 (1991), we construe the "objective findings" requirement to be satisfied if the physician's evaluation of a worker's physical condition is based on a claimant's description of the pain he is experiencing. The report, however, cannot merely recite the claimant's complaints of pain, but rather must indicate that the claimant does, in fact, experience symptoms. Id.

Here, we find that there is a divergence of medical opinion concerning whether objective findings are present to support claimant's claim. Dr. Jewell, an independent medical examiner, noted that claimant had ulnar aspect "symptomatology." However, Jewell also suspected functional interference. (Ex. 9-2). Additionally, Dr. McHolick, an associate of claimant's treating orthopedist (Dr. Macha), recommended that claimant return to work. (Ex. 23(b) at 5).

On the other hand, Dr. Macha found tenderness and swelling over the ulnar nerve at claimant's elbow, a mildly positive Tinel sign over the cubital tunnel and a mildly positive elbow flexion test. (Ex. 23(b) at 5-6). Mild irritability of the ulnar nerve to palpation was also documented by Dr. Macha. (Ex. 23(b) at 8). In response to these findings, Macha prescribed an elbow pad and injections of Marcaine and Decadron. (Ex. 23(b) at 8-9). Dr. Macha referred claimant to Dr. Goins, a neurologist. Finding that claimant's nerve conduction and needle tests were normal, Dr. Goins noted a "lack of significant objective findings." (Ex. 17-1). Nevertheless, upon reexamination, Dr. Goins reported that "it is again clear that there is some pain over the right cubital tunnel region." (Ex. 17-1).

Where there is a dispute between medical experts, we tend to give greater weight to the conclusion of the treating physician unless we find another opinion more persuasive. Somers v. SAIF, 77 Or App 259 (1986); Taylor v. SAIF, 75 Or App 583 (1985). Here, we find no persuasive reason not to defer to Dr. Macha's observations and findings as the treating physician. Recognition of claimant's complaints was further confirmed by Dr. Goins and Dr. Jewell. Finally, Jewell's suspicion of functional interference is not borne out by other medical experts or the remainder of the record. Consequently, we conclude that claimant's claim has been established by medical evidence supported by objective findings. ORS 656.005(7). Accordingly, we affirm the Referee's decision to set aside the insurer's denials.

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). We note that a portion of claimant's counsel's efforts here was expended defending against the insurer's effort to reduce the assessed fee awarded at hearing. No assessed fee is payable for such efforts. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). With this in mind, and considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability and aggravation issues is $1,000. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and statement of services), the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated June 11, 1991 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the insurer.

March 10, 1992 Cite as 44 Van Natta 420 (1992)

In the Matter of the Compensation of
PATRICIA A. PANTEKOEK, Claimant
WCB Case No. 88-11361
ORDER ON REMAND
Stebbins & Coffey, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Roseburg Forest Products v. Pantekoek, 108 Or App 190 (1991). The court reversed our prior order, which found that claimant had established that her work activity was a material contributing cause of her cervical problems and, therefore, had proved a compensable occupational disease claim. The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), which held that a claimant must establish that her employment was the major contributing cause of her claimed condition or its worsening in order to prove a claim for occupational disease under former ORS 656.802(1)(c).

FINDINGS OF FACT

We republish our prior "Findings of Fact" contained in our August 10, 1990 order. We do not republish our "Findings of Ultimate Fact." We add the following supplementation.

Claimant began working in the mill for the employer in September 1986. Prior to that time, claimant had no hand or wrist complaints, no upper extremity complaints and no neck complaints. She had no history of injury, nor had she

engaged in physical labor or recreational activities involving vigorous use of her upper extremities.

Claimant worked in the mill for four months and saw Dr. Mann for upper extremity complaints and was treated for carpal tunnel syndrome. Claimant was off work until November 1987, when she returned to the mill and worked as a "skoog" operator, working three days per week and lifting 60 pound trays.

Claimant began experiencing increased pain radiating up and down her arm. Claimant suffers from cervical stenosis and disc herniation at level 4-5, which is not a result of a degenerative disease or a part of the natural aging process.

ULTIMATE FINDINGS OF FACT

Claimant's work activities for the employer were the major contributing cause of her cervical stenosis and disc herniation, which resulted in her disability and need for medical services.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's cervical condition was related to her work activities, the Referee set aside the employer's denial of claimant's occupational disease claim. We affirmed the Referee's order. Relying on our order in Donna E. Aschbacher, 41 Van Natta 1242 (1989), we found that claimant had established that she suffers from an occupational disease and that her work activities were a material contributing cause of her increased neck symptoms which resulted in disability and need for medical services. In Aschbacher, we held that, under the 1987 amendments to former ORS 656.802(1), a claimant could prove a compensable claim for occupational disease under former ORS 656.802(1)(c) by merely showing that work was a material contributing cause of a claimed condition or a worsening of the symptoms of a preexisting disease.

The Court of Appeals subsequently reversed our order in Aschbacher, holding that the legislature had not intended to change the standard of proof necessary to prove a claim under former ORS 656.802(1)(c) and that a claimant was still required to show that the work activity was the major contributing cause of a claimed condition or worsening of an underlying disease. Aetna Casualty Co. v. Aschbacher, supra. Relying on its decision in Aschbacher, the court has reversed and remanded our decision in claimant's case for reconsideration.

We republish those portions of our previous reasoning and opinion that found that claimant suffers from an occupational disease and that claimant's case should be analyzed under former ORS 656.802, effective January 1, 1988.

Major contributing cause means an activity or exposure or combination of activities or exposures which contributes to the onset or worsening more than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145 (1983); Dethlefs v. Hyster Co., 295 Or 309 (1983); Leo R. Cox, 43 Van Natta 2354 (1991). The causation issue is a complex medical question, requiring expert medical evidence for its resolution. See Uris v. Compensation Department, 247 Or 420; Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). When there is a dispute between medical experts, we generally give greater weight to the conclusion of the treating physician unless there is a persuasive reason not to do so or we find another opinion is more thorough and well-reasoned. See Taylor v. SAIF, 75 Or App 583 (1985); Somers v. SAIF, 77 Or App 259 (1986).

Here, there is a dispute between medical experts. The Orthopaedic Consultants opined that claimant suffered from cervical spondylosis which antedated

claimant's employment and was not caused by her prior compensable 1986 carpal tunnel syndrome. On the other hand, Dr. Jones, claimant's treating orthopedic surgeon, concluded that claimant was suffering from cervical stenosis, which was a partial closure of the spinal canal caused by claimant's herniated disc at C-4-5. (Ex. 33 at page 29). Jones further opined that the herniation was not the result of a degenerative or aging process. (Ex. 33 at pages 32-33). Based on his diagnosis and the fact that claimant had no hand, wrist, neck or upper extremity complaints prior to working for the employer, Jones opined to a medical probability that claimant's work activities for the employer were "the material" contributing cause of her current cervical condition. (Ex. 33 at pages 31 and 38-39).

We find the Orthopaedic Consultants' opinion unpersuasive because it is conclusory as to both its diagnosis and the causation issue. The Orthopaedic Consultants examined claimant only once on March 23, 1988 and opined later, without any explanation, that claimant's spondylosis antedated her employment.

In contrast, we find Dr. Jones' opinion thorough and well-reasoned. It explains the reason why claimant's cervical problem went undetected by Dr. Mann and the spurring evidenced in claimant's 1987 x-rays. Moreover, he has been claimant's treating orthopedist since May 27, 1987. Finding no persuasive reason not to defer to his opinion, we rely on Dr. Jones' opinion. Taylor V. SAIF, supra.

In reaching this conclusion, we note that Dr. Jones stated that claimant's work activities "materially" contributed to her cervical condition. However, "major" and "material" are legal terms and not medical terms and these "magic words" are not required to quantify the magnitude of causation. McClendon v. Nabisco Brands, 77 Or App 412 (1986). Taken as a whole, we interpret Dr. Jones' opinion to mean that claimant's work activities for the employer were, at least the major, if not the sole, contributing cause of her cervical condition and need for treatment.

Accordingly, on reconsideration, the Referee's order dated February 13, 1989 is affirmed.

Inasmuch as claimant has finally prevailed before the Board after remand from the court, she is entitled to a reasonable attorney fee for services before every prior forum. See ORS 656.388(1). Since claimant's counsel provided services before the court, a reasonable fee for such efforts shall be awarded. Id.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel before the court is $1,500, to be paid by the employer. This fee is in addition to claimant's prior attorney fee awards for services rendered at the hearings level and on Board review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the issue involved, and the risk that claimant's attorney's efforts may go uncompensated.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUSSELL TILLERY, Claimant
WCB Case No. C2-00278
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, Bruun & Green, Claimant Attorneys
Meg Carman, Defense Attorney

Reviewed by Board Members Neidig and Moller.

On February 6, 1992, 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.

On February 19, 1992, in lieu of a formal addendum, the parties submitted an "addendum response letter" to the Board. This letter provided the required clarification as requested by the Board, however, it does not purport to make actual changes to the CDA.

Upon review of the document and letter as a whole, it appears the parties propose to distribute settlement proceeds totaling $17,500. Further, the parties propose to distribute these proceeds as follows: $3,500 as the total due attorney and $14,000 as the total due claimant. These provisions have been made by handwritten revision. All parties have been advised of these changes. The Board has received no objection by any of the parties to these revisions. Therefore, the Board assumes both parties are in agreement with this change. Accordingly, we approve the proposed amended agreement for a total consideration of $17,500 to be distributed in accordance with the representations made by the summary page.

The amended agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this amended claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of the agreement is also approved.

The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA A. WILLIAMS, Claimant
WCB Case No. 90-10056
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Daron's order which: (1) found that claimant's psychological condition was not causally related to her compensable left shoulder and cervical conditions; and (2) upheld the SAIF

Corporation's denial of claimant's aggravation claim for a psychological condition. On review, the issues are compensability and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the third paragraph on page 2 of the Opinion and Order. We supplement the adopted findings as follows.

In 1990 claimant began treating with psychiatrist Dr. Hayes for a psychological condition which was diagnosed as major depression, moderate, single episode. (Ex. 22-2). Dr. Holland, an independent examining psychiatrist, diagnosed claimant's condition as Somatoform Pain Disorder and Dysthymia, secondary to Somatoform Pain Disorder (Ex. 28-24). Dysthymia is closely correlated to Major Depression. (Ex. 37).

Dr. Hayes opined that but for the work injury and its sequelae, claimant would not be depressed because she could cope with the other stressors in her life. (Ex. 35). Dr. Holland opined that the 1984 work injury precipitated claimant's psychological condition, while claimant's preexisting psychological profile and continuous financial problems are perpetuating factors. (Ex. 28-26).

FINDINGS OF ULTIMATE FACT

The 1984 work injury and its sequelae, including cervical surgery, were the major contributing cause of claimant's psychological condition.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

On May 7, 1990, the Governor signed into law Senate Bill 1197, a comprehensive revision of the workers' compensation law. Or Laws 1990 (Special Session), ch. 2. The hearing in this case was convened after July 1, 1990. Therefore, the "savings clause" contained in section 54(2) does not apply. In addition, the matters at issue concerning compensability and an aggravation claim are not subject to a special exception to the Act's general applicability provision. See, e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze those matters under the Workers' Compensation Act as amended, effective July 1, 1990.

Compensability

The Referee concluded that claimant's psychological condition is not compensable because she failed to establish that her 1984 compensable left shoulder and cervical injury was the major contributing cause of the psychological condition. We reverse.

Claimant seeks compensation for a psychological condition she alleges arose from a 1984 compensable injury and its sequelae, including compensable cervical surgery performed in 1989. Because claimant alleges the condition is a "consequence" of conditions previously deemed compensable, the psychological condition is a "secondarily consequential condition," and claimant must show that the compensable injury is the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151 (1991). The issue of whether claimant's compensable conditions are the major contributing cause of claimant's current psychological condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of the 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).

Claimant relies on the opinion of her treating psychiatrist, Dr. Hayes, who concluded that "pain, diminished function, inability to be employed and a diminished sense of self-worth are the major contributing factors in relation to her depression." (Ex. 33). In a letter dated December 5, 1990, Dr. Hayes further explained that claimant's depression "is directly related to the pain she identifies, her stated loss of function in her role of wife, homemaker, and her ability to be employed." Finally, Dr. Hayes stated: "It is my opinion that if she did not have the injury and its limitations she could cope with the other stressors and not be depressed." (Ex. 35) (emphasis added).

SAIF points out that Dr. Hayes also stated in his December 5, 1990, letter (Ex. 35) that the 1984 injury contributed only "materially" to claimant's depression. SAIF also argues that Dr. Hayes "could not say" that the 1984 injury was the major contributing cause of the psychological condition. At issue are Dr. Hayes' opinions, offered in response to claimant's attorney's request.

Reading Dr. Hayes' two letter opinions together, we find that Dr. Hayes responds affirmatively to the question of whether the injury and its sequelae are more significant than other stressors. Based on Dr. Hayes' opinion, we conclude that claimant would not suffer from her psychological condition if it were not for her compensable shoulder, arm and cervical conditions.

Claimant sought psychological treatment from Dr. Hayes to help her cope with chronic pain following the compensable cervical surgery in 1989. (See, e.g., Exs. 12A, 17, 21-1, Tr. 11-12). There is no evidence that claimant has had any previous psychological treatment, although there is evidence that claimant made a suicide attempt at age 17 and took antidepressant medication at one time. (Ex. 22-1, Ex. 28-14). The Referee found, and we agree, that claimant has chronic pain that limits repetitive use of her neck and left shoulder and arm, and that claimant is unable to perform clerical/computer jobs, for which she has training, due to strict limitations on use of her neck and left shoulder and arm.

Under these circumstances, we find that all of the factors Dr. Hayes identified as "the major contributing" cause of claimant's psychological condition (pain, diminished function, inability to be employed, diminished sense of self-worth) (Ex. 33), directly relate to the effects of the 1984 compensable injury, including the 1989 cervical surgery. We further find that it is Dr. Hayes' opinion that but for the 1984 injury and its sequelae, claimant would not be depressed. Accordingly, although Dr. Hayes refused to respond in a "yes or no" fashion to the complex question of whether the compensable injury and its sequelae were more significant than other factors, we conclude that Dr. Hayes' opinions, when read together, establish that the compensable shoulder and neck conditions were the major contributing cause of claimant's current psychological condition. In reaching this conclusion, we note that no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

SAIF argues that we should rely on the opinion of Dr. Holland, a psychiatrist who performed an independent medical examination. However, we tend to give greater weight to the opinions of claimant's treating doctor, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no persuasive reasons not to do so in this case.

Moreover, we find that Dr. Holland's opinion does not conflict with the opinion of Dr. Hayes. Dr. Holland's diagnosis is similar to Dr. Hayes' diagnosis of depression, and Dr. Holland himself found no significant conflict between Dr. Hayes' evaluation of claimant and his own. (Ex. 37). Dr. Holland believes there is an indirect relationship between claimant's compensable injury and her psychological condition. (Ex. 28-27). He also states that there is no direct causal relationship between the compensable injury and psychological condition (Ex. 32; see also Ex. 27), but this opinion is not pertinent to establishing compensability of a secondarily consequential condition. Julie K. Gasperino, supra.

Although Dr. Holland states that the compensable 1984 injury was not the major contributing cause of claimant's psychological condition (Ex. 32), we look to his explanation of this conclusion. Dr. Holland explains that there are predisposing, precipitating, and perpetuating factors to claimant's condition, which he diagnosed as somatoform pain disorder and dysthymia, secondary to the pain disorder. Dr. Holland found that the precipitating factor was claimant's compensable injury in 1984, and that her compensable surgery contributed to the pain disorder. (Ex. 28-26). Accordingly, we conclude that Dr. Holland's opinion does not conflict with our conclusion that claimant's compensable injury and its sequelae are the major contributing cause of her psychological condition.

Aggravation

SAIF's only basis for denying the claim is that the 1984 injury was not the major contributing cause of the psychological condition. (Ex. 31). In light of our decision above, the basis for SAIF's objection has been resolved. In any event, Dr. Hayes concluded that claimant is unable to work as a result of her psychological condition. (Ex. 22-3). Inasmuch as we have found claimant's psychological condition to be compensable, it follows that claimant's compensable injury has worsened since the last award or arrangement of compensation. ORS 656.273(1). Accordingly, we also set aside SAIF's denial of the aggravation claim.

Attorney Fee

Claimant is entitled to an assessed attorney fee for her counsel's services at hearing and on review concerning this matter. 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 $3,000 is a reasonable fee, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's brief), the value of the interest involved, the complexity of the issues, and the risk that claimant's attorney may go uncompensated.

ORDER

The Referee's order dated April 8, 1991, as amended April 19, 1991, is reversed in part. The SAIF Corporation's denial is set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,000, payable by SAIF. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
TONY M. ZUNIGA, Claimant
WCB Case No. 90-14141
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Lipton's order which: (1) upheld the self-insured employer's denial of claimant's aggravation claim for his ankle condition; (2) found claimant was not entitled to interim compensation; and (3) declined to assess penalties and related attorney fees for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are aggravation, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

Aggravation

The Referee concluded that claimant had failed to establish a compensable aggravation of his left ankle. We agree.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 22 (1989) rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Dr. Puziss' chart notes and reports establish that claimant's ankle condition had worsened following the March 1990 incident. This worsening is supported by Dr. Puziss' objective findings of tenderness of the deltoid ligament, tenderness of the anterior talofibular ligaments, tenderness of the fibula calcaneal ligament, tenderness of the posterior talofibular ligament and posterior lateral ecchymosis. Finally, Dr. Puziss took claimant off work following the March 1990 incident. Accordingly, we find that claimant sustained a worsening of his left ankle condition that is supported by objective findings and resulted in diminished earning capacity. Consequently, claimant has established a worsened condition.

Inasmuch as the March 1990 incident, which did not occur in the course and scope of his employment, contributed to his worsened condition, he must also prove legal causation.

Generally, a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if there is an off-

work injury which is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991).

The only opinion regarding causation of claimant's ankle condition is that of Dr. Puziss. Dr. Puziss initially indicated that the major contributing cause of claimant's left ankle condition was the March 15, 1990 noncompensable incident, which occurred when claimant was exiting a car.

The history claimant initially reported to Dr. Puziss was that claimant's left knee gave out as he was getting out of a car. He then felt a twist of the left ankle and a pop and had instant swelling and pain. Six days before hearing, claimant changed this history, reporting that his left ankle, not knee, had given out resulting in this injury. Based on this new history, Dr. Puziss re-evaluated his former opinion and concluded that the March 3, 1988 compensable injury was the major contributing cause of claimant's ankle condition.

After reviewing this record, we agree with the Referee's conclusion that the history as initially given to Dr. Puziss is likely to be more accurate. We agree that if the history originally taken was incorrect, there was a lengthy delay in correcting it. We note that even Dr. Puziss felt that it was "unusual to have a not so subtle change in the story just before a hearing."

Next, claimant argues that even if it was claimant's left knee which gave out, this incident is still compensable because the left knee is part of this claim. Claimant points to medical records after claimant's sympathectomy surgery which indicate that after the surgery claimant had problems with his left leg, which included giving way of the left knee and ankle. However, Dr. Puziss indicates that after the problems with the left knee which were related to the sympathectomy, claimant had not reported problems with the left knee since about June of 1989. (Ex. 69-25). There is no medical opinion which indicates that a give way of the knee on March 15, 1990 is related to claimant's compensable March 3, 1988 ankle injury.

Under these circumstances, we accept Dr. Puziss' initial opinion, based on the history that claimant's knee gave way leading to the ankle injury, that the March 15, 1990 incident is the major contributing cause of claimant's worsened condition. Accordingly, claimant's worsened left ankle condition is not compensable.

Claimant asserts that the employer's denial also denied that claimant's current condition and need for treatment and disability was related to claimant's compensable March 3, 1988 injury.

Inasmuch as we have concluded that the March 1990 incident was the major contributing cause of claimant's worsened left ankle condition, it follows that he is not entitled to medical services for the worsened condition. See Elizabeth A. Bonar-Hanson, supra.

However, when claimant's worsened condition resolves, if the compensable injury remains a material contributing cause of his underlying ankle condition, this condition would remain compensable. Moreover, claimant may be entitled to continuing medical services provided that such services are related to the compensable condition rather than the noncompensable worsened condition.

Interim Compensation

The Referee found claimant was not entitled to interim compensation because there was no evidence that interim compensation was not in fact paid. On

review, claimant points out that the employer stipulated that no interim compensation had been paid. We therefore address claimant's entitlement to those benefits.

Entitlement to interim compensation in the form of temporary total disability depends on whether, before denial of an aggravation claim, there was "a medically verified inability to work resulting from a compensable worsening supported by objective findings." ORS 656.273(6). In Doris A. Pace, 43 Van Natta 2526 (1991), we construed that language as requiring notice or knowledge of an inability to work as documented in a medical report that constitutes prima facie evidence of a compensable worsening.

Here, Dr. Puziss' reports do not constitute medical verification of an inability to work due to a compensable worsening. Dr. Puziss' reports establish that claimant was unable to work due to a worsened condition and his March 19, 1990 report contains a recitation of objective findings. However, Dr. Puziss' reports do not address whether the worsened ankle condition is more than a waxing and waning of symptoms contemplated by the last award of compensation. See ORS 656.273(8); Theresa L. Loomas, 44 Van Natta 231 (1992). Accordingly, because Dr. Puziss' reports were not prima facie evidence of a compensable worsening, claimant was not entitled to interim compensation benefits.

Inasmuch as the employer was not obligated to pay interim compensation, it follows that penalties and attorney fees are not warranted for the employer's failure to pay interim compensation.

ORDER

The Referee's order dated April 24, 1991 is affirmed.

March 11, 1992 Cite as 44 Van Natta 429 (1992)

In the Matter of the Compensation of
FRED A. BILLINGS, JR., Claimant
WCB Case No. 90-22127
ORDER ON REVIEW
C. David Hall, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant requests review of Referee Knapp's order that upheld the insurer's December 12, 1990 denial of his injury or occupational disease claim for a low back condition. On review, the issue is compensability.

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

The Referee stated that it is claimant's burden to establish that his December 1989 work injury or work exposure was the major contributing cause of his current low back condition, citing ORS 656.005(7)(a)(A)[1] and 656.802(1)(c). On review, claimant contends that his claim is for a new low back injury only. We disagree with claimant's characterization of the claim.

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[1] In this regard, we note that the standard of proof for an initial or "new" injury is material contributing cause. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Claimant stated that he did not seek treatment for his back between 1988 and May 1990, because he thought such treatment would not be covered under his 1983 back injury claim. He also stated that he would have sought treatment during that time, had he known it was available under the prior claim. These statements suggest to us, as they did to the Referee, that claimant's current back problems may be continuing, rather than new. Moreover, although claimant identifies December 1989 as his "date of injury," he did not seek treatment until May 1990. Considering claimant's inconsistent reporting concerning his symptoms and his delay in seeking treatment following the claimed December 1989 onset, we are not persuaded that his recent back problems were sudden in onset. Considering these circumstances, we agree with the Referee's determination that the present claim is properly analyzed as a disease rather than as an injury. See Valtinson v. SAIF, 56 Or App 184, 187 (1982); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). Accordingly, to carry his burden, claimant must establish that his work exposure with the insured was the major contributing cause of his recent need for treatment for a low back condition. ORS 656.802(1)(c).

The only medical evidence which arguably supports claimant's current claim is the December 1990 opinion of Douglas Bald, M.D., and James Watson, M.D., of Western Medical Consultants. However, due to claimant's inconsistent reporting, we are unable to determine whether these doctors had an accurate history. Therefore, we do not find their opinion regarding causation to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986). While claimant's problems in the early years after his 1983 injury were more in the mid than low back area, he did have low back complaints, which were accepted as part of the 1983 claim by stipulation in 1988. In the absence of persuasive expert evidence supporting the claim, we conclude, as did the Referee, that claimant has not carried his burden.

Assuming arguendo, that the claim is for an injury, rather than an occupational disease, it would be claimant's burden to show, by a preponderance of the evidence, that as a result of a specific work-related event, he became disabled or required treatment. On this record, we cannot conclude that it is more likely than not that a specific injury occurred in December 1989 which was a material cause of claimant seeking treatment or being disabled 6 months later.

Therefore, whether the claim is analyzed as one for an injury or for an occupational disease, we conclude that the denial was correct and should stand.

ORDER

The Referee's order dated April 2, 1991 is affirmed.

March 11, 1992 Cite as 44 Van Natta 430 (1992)

In the Matter of the Compensation of
ANTHONY M. SABBATO, Claimant
WCB Case No. 90-09151
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Daryl Nelson, Defense Attorney

Claimant requests reconsideration of that portion of our February 13, 1992 Order on Review that upheld the insurer's denial to the extent that it denied claimant's current resultant lung condition. Specifically, claimant contends that the only issue before the Referee and the Board was whether or not claimant had sustained a compensable injury or occupational disease and not whether

claimant's compensable condition was the major contributing cause of a resultant condition pursuant to ORS 656.005(7)(a)(B). We disagree.

The insurer's April 24, 1990 denial stated that claimant's current condition was denied as "[i]nsufficient evidence exists to justify a contention that your condition is the result either of an injury or a disease precipitated by your occupational exposure at (the employer's)." At hearing, claimant stated that whether or not the issue was viewed as compensability, "what's really at issue is the denial that's marked as Exhibit 24. That's the denial of April 24."

On direct examination, claimant testified regarding his preexisting lung condition and prior medications and treatment. (Tr. 5). Additionally, the insurer also questioned a witness about claimant's preexisting condition. (Tr. 12). Finally, on review, the insurer contended that ORS 656.005(7)(a)(B) was applicable.

Under the circumstances, we agree with claimant that, because the denial was issued prior to the 1990 amendments, it did not treat the issue of his resultant condition separately. However, we conclude, after reviewing the arguments of counsel, that the issue was raised and litigated by the parties pursuant to ORS 656.005(7)(a)(B). See Thomas Porter, 43 Van Natta 2599 (1991).

Accordingly, we continue to conclude that, although claimant established compensability of his December 6, 1989 injury, he has failed to prove that the injury is the major contributing cause of the resultant disability or need for medical treatment.

Accordingly, our February 13, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 13, 1992 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

March 11, 1992 Cite as 44 Van Natta 431 (1992)

In the Matter of the Compensation of
WILLIAM C. SCHNEIDER, Claimant
WCB Case No. 90-17690
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of those portions of Referee Spangler's order which: (1) upheld that portion of the self-insured employer's denial which denied claimant's current right knee condition and need for medical treatment (total knee replacement); and (2) declined to award penalties or associated fees for an allegedly unreasonable denial. On review, the issue is compensability of claimant's current right knee condition and penalties and fees. We affirm.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

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

The November 1988 right knee injury was a material factor in claimant's increased symptoms of his preexisting anterior cruciate ligament condition.

The major contributing cause of claimant's current right knee condition and need for treatment is conditions which preexisted his compensable 1988 right knee torn menisci injury.

OPINION AND CONCLUSIONS

Compensability of Current Condition

We adopt the Referees conclusions and reasoning concerning the compensibility of claimant's current right knee condition. See Bahman M. Nazari, 43 Van Natta 2368 (1991).

Penalties and Attorney Fees

We adopt the Referee's conclusions and reasonings with the following supplementation.

Claimant contends that the back-up denial was impermissible because the carrier was aware of claimant's previous right knee injuries prior to accepting the November 1988 claim. To the contrary, the record establishes that the 801 form which was submitted to the carrier was not filled out by claimant, indicated no prior knee injuries, and referred to the injury as a strain. After that point, and prior to issuance of the carrier's denial, it became apparent that claimant had very significant prior knee injuries and that the instant injury had not been a strain. This information and its significance was revealed prior to the denial. The carrier appropriately relied upon ORS 656.262(6) in issuing its denial.

ORDER

The Referee's order dated April 16, 1991 is affirmed.

March 11, 1992 Cite as 44 Van Natta 432 (1992)

In the Matter of the Compensation of
LINDA D. THOMAS, Claimant
WCB Case No. 90-14356
AMENDED ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

It has come to the Board's attention that the February 12, 1992 Order on Review in this matter may cause confusion regarding the date of claimant's last award or arrangement of compensation for purposes of proving a compensable aggravation claim. We issue this order to clarify that date.

We decline to accept the Referee's finding of fact that claimant's last award or arrangement of compensation was a Determination Order dated June 26, 1990. Indeed, no Determination Order issued on that date. Rather, that was the

date of issuance of the prior Referee's Opinion and Order, which awarded claimant 5 percent unscheduled permanent disability.

In any event, we adhere to our conclusion that claimant must prove a worsening since the date of the final opportunity to present evidence. Joseph Klinsky, 35 Van Natta 332, aff'd mem., 66 Or App 193 (1983). Here, that date was the May 31, 1990 hearing which culminated in the June 26, 1990 Opinion and Order.

Accordingly, we withdraw our February 12, 1992 order. As amended herein, we adhere to and republish our February 12, 1992 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
STEVEN V. BISCHOF, Claimant
WCB Case No. 90-10882
ORDER ON RECONSIDERATION
Sellers & Jacobs, Claimant Attorneys
Cooney, et al., Defense Attorneys

Claimant requests reconsideration of our February 14, 1992 Order on Review. In that order we concluded that we lacked jurisdiction to address whether claimant's accepted nondisabling injury had become disabling and vacated the Referee's order. The self-insured employer responded to claimant's request for reconsideration. On February 27, 1992, we withdrew our order to allow sufficient time to consider the motion. After further consideration of the matter, we issue the following order.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law in effect before the 1990 amendments. See Oregon Laws 1990 (Special Session), SB 1197. We apply the law in effect after the amendments for the following reasons.

Claimant requested a hearing after May 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Temporary Disability

The Referee concluded that claimant's claim became disabling by definition pursuant to former ORS 656.005(7)(b), renumbered as ORS 656.005(7)(c), when his treating physician took him off work for two weeks. The employer argues that it paid time loss from March 2, 1990 through March 15, 1990 and claimant is not entitled to temporary disability beyond that date.

At the outset we note that the employer contends that the Referee did not have jurisdiction over this matter on the basis that the Director must determine whether a claim should be reclassified as disabling in the first instance. While we agree that we do not have original jurisdiction to determine whether claimant's claim has become disabling, we do not find claimant's disabling/nondisabling status at issue in the present case. Rather, we find that the actual issue presented here is claimant's procedural entitlement to temporary disability benefits. See ORS 656.268(3). By deciding claimant's procedural entitlement to temporary disability, we do not reach the disabling/nondisabling status issue, which is within the Director's jurisdiction, nor the substantive entitlement issue, which will be determined at claim closure.

On March 2, 1990, claimant was released from work for two weeks by his attending physician, Dr. Jackson, M.D. The employer paid temporary disability from March 2 through March 15, 1990. After an investigation in which the employer determined that claimant's claim had not become disabling, it issued a denial to that effect and unilaterally stopped paying temporary disability. On review, the employer argues that it did not unilaterally terminate claimant's temporary disability benefits because it issued a denial that the claim was ever disabling. We find that the issuance of the denial does not make the employer's termination of temporary disability benefits any less unilateral.

Since the Referee's decision, we decided Soledad Flores, 43 Van Natta 2504, 2507 (1991), in which we found that, if one of the conditions set forth in amended ORS 656.268[1] was met a carrier could procedurally terminate temporary disability without the claimant also being medically stationary. Thereafter, upon claim closure, a claimant's substantive entitlement to temporary disability benefits would be determined. Soledad Flores, supra at 2504. In addition, a carrier is entitled to offset any temporary disability benefits paid in excess of a claimant's substantive entitlement against permanent disability awards. Soledad Flores, supra at 2507.

The question here is whether any condition provided in amended ORS 656.268 for unilateral termination of temporary disability benefits was met. We conclude that none of the conditions were met; and therefore, the employer unlawfully terminated claimant's temporary total disability benefits.

First, claimant did not return to regular work with the employer, nor was he released to return to regular work. Claimant's regular work was his at injury job, which was making repairs at the "cry station." Both claimant's attending physician and the company doctor viewed videos of claimant changing the oil in his car on March 12 and 13, 1990 and of a worker performing a job at the "lube station." (Exs. 19, 20). On the basis of these videos, both physicians

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1 Amended ORS 656.268 provides, in part:

"(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker returns to regular or modified employment;

"(b) The attending physician gives the worker a written release to return to regular employment; or

"(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

released claimant to perform work at the lube station. Claimant's supervisor testified that these jobs were equal. (Tr. 49). However, the lube station job was not the job claimant had when he was injured. Furthermore, neither physician was shown a video of a worker performing the cry station job. On this basis, we conclude that claimant was released to modified work rather than regular work.

Claimant was released by his attending physician to modified work on March 19, 1990. (Ex. 20). The next day, before claimant could begin the modified work, he was terminated. The employer did not offer the modified employment in writing to claimant. Accordingly, none of the requirements provided in ORS 656.268(3) for unilateral termination of benefits were satisfied. Thus, claimant is procedurally entitled to the temporary disability benefits awarded by the Referee.

Attorney Fees

Based on a substantive analysis, the Referee found that claimant was entitled to temporary disability benefits from March 16, 1990 through September 10, 1990. He awarded claimant's attorney an approved fee of 25 percent of the increased compensation made payable by his order. Although have found that claimant is entitled to temporary disability for the same period based on a procedural analysis, the Referee's attorney fee award is and remains correct. See Virginia Wolf, 40 Van Natta 1725 (1988).

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. 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 attorney's services on review concerning the temporary disability issue is $800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services and request for reconsideration), the complexity of the issue, and the value of the interest involved.

ORDER

Our Order on Review dated February 14, 1992 is withdrawn. The Referee's order dated April 3, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by the self-insured employer.

March 12, 1992 Cite as 44 Van Natta 435 (1992)

In the Matter of the Compensation of
DAREN S. KIRKPATRICK, Claimant
WCB Case No. 91-01633
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Gruber's order which set aside its denial of compensability of medical services for a cervical condition. On review, the issue is compensability of medical services.

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

It is undisputed that claimant's aggravation rights have expired and that he is subject to this Board's Own Motion jurisdiction. ORS 656.278. SAIF contends that because the claim is in Own Motion status, the Referee did not have jurisdiction over this dispute to determine whether claimant's current condition and need for medical services are compensably related to the 1977 accepted claim. We disagree.

Because claimant's aggravation rights have expired, claimant must request Own Motion relief to obtain temporary disability compensation during hospitalization or while undergoing surgery for the compensable condition. ORS 656.278(1). On the other hand, an injured worker is entitled, by right, to time medical services, i.e., "for such period as the nature of the injury or the process of recovery requires, including such medical services as may be required after a determination of permanent disability." ORS 656.245(1)(a). Where a denial of a medical services claim is based on the assertion that the condition for which treatment is sought is not causally related to the compensable injury, the question of a material or major contributing causation is a "matter concerning a claim," over which this Board, including its Hearings Division, has jurisdiction. Michael A. Jaquay, 44 Van Natta 173 (1992). In the event of such denial, the worker may request a hearing pursuant to ORS 656.283 and ORS 656.245(2).

Here, SAIF denied claimant's medical services claim on the ground that his current cervical condition is not compensably related to the 1977 accepted injury. The Referee did not order payment of any temporary disability compensation. The question of compensability raised by SAIF's denial is properly before this Board. Michael A. Jaquay, supra.

SAIF requested review and claimant's compensation has not been disallowed or reduced. Therefore, claimant is entitled to a reasonable attorney fee award. 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 is $1,425, 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 and statement of services submitted), the complexity of the issue, the value of the interest involved, and the risk in this case that claimant's attorney's services might go uncompensated.

ORDER

The Referee's order dated June 14, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of $1,425, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JIMMY L. MASSEY, Claimant
WCB Case Nos. 90-04901 & 89-03725
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Tenenbaum's order that: (1) declined to grant permanent total disability; and (2) increased

claimant's unscheduled permanent disability for a low back condition from 30 percent (96 degrees), as previously awarded, to 48 percent (153.6 degrees). The SAIF Corporation cross-requests review of those portions of the order that: (1) found that claimant's psychological condition was compensable and awarded an impairment value for that condition; and (2) declined to authorize an offset of the alleged overpayment made pursuant to a Determination Order. Claimant moves the Board for an order striking SAIF's brief on the ground that the brief was not served on claimant's attorney contemporaneously with the filing of the brief with the Board. Claimant also moves to strike another referee's order which SAIF attached to its brief. On review, the issues are motion to strike, hearing procedures, offset, and extent of unscheduled permanent disability, including permanent total disability. We deny the motions to strike, reverse in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions. We do not adopt the third full paragraph on page 6 or the first two paragraphs on page 7 of the order. Claimant is entitled to an 8 percent impairment value for the two chymopapain injections. He is entitled to 5 percent for a chronic condition limiting repetitive use of his lumbar spine. He has normal lumbar range of motion. (Ex. 118-3).

FINDINGS OF ULTIMATE FACT

On March 12, 1991, subsequent to this Referee's order, another referee found claimant's psychological condition not compensable. That referee's order was not appealed and became final by operation of law.

Claimant is not permanently and totally disabled for medical reasons alone. Nor is he permanently and totally disabled as a result of a combination of medical and nonmedical factors. Moreover, claimant has not established that he is willing to work and has made reasonable efforts to find work. Such work search efforts would not be futile.

CONCLUSIONS OF LAW AND OPINION

The hearing request in this case was filed before May 1, 1990 and the hearing was convened before July 1, 1990. Therefore, the "litigation savings clause" to the 1990 amendments to the Workers' Compensation Act applies. See Oregon Laws 1990 (Special Session), chapter 2, section 54(2). Accordingly, we apply the law in effect before the 1990 amendments.

Motions to Strike

Claimant moves the Board for an order striking SAIF's brief on the ground that the brief was not served on claimant's attorney contemporaneously with the filing of the brief with the Board. Claimant contends, and the record indicates, that, on May 23, 1991, SAIF mailed a copy of its respondent's/cross-appellant's brief to claimant's attorney's former address. However, claimant's attorney received a facsimile of that brief on May 30, 1991. Furthermore, claimant's reply brief was timely filed. Thus, claimant has not shown that he was prejudiced by SAIF's failure to mail its brief to claimant's attorney's current address. Under these circumstances, we conclude that SAIF's respondent's/cross-appellant's brief should not be stricken. See David F. Weich, 39, Van Natta 468 (1987), James M. Kleffner, 38 Van Natta 1413 (1986). Accordingly, the motion to strike SAIF's respondent's/cross-appellant's brief is denied.

In the alternative, claimant moves to strike a March 12, 1991 order issued by Referee Borchers relating to the compensability of claimant's psychological

condition. SAIF attached a copy of the order to its brief. The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." This has been held to include agency orders. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Grace B. Simpson, 43 Van Natta 1276 (1991); Susan K. Teeters, 40 Van Natta 1115 (1988). Inasmuch as this agency order is germane to the issues before us, we take administrative notice of it.

Hearing Procedure

The Referee found claimant's psychological condition compensable and assigned it an impairment value of 35 percent. On review, SAIF argues that the Referee erred in deciding the compensability of claimant's psychological condition and rating it because neither party raised those issues at hearing. We agree with SAIF.

At hearing, SAIF's attorney noted that: (1) claimant's psychological condition had been denied; and (2) SAIF had made a recommendation to the Board against reopening claimant's claim under own motion status on the basis of the psychological condition. (Tr. 36, 37). Both SAIF's attorney and claimant's attorney agreed that the compensability of the psychological condition was not before the Referee. (Tr. 24, 38). However, claimant's attorney argued that the Referee could consider this condition in the evaluation of permanent total disability under the odd lot doctrine. (Tr. 38).

On this record, we find that neither party raised the issue of the compensability of claimant's psychological condition. Thus, that issue was not properly before the Referee. Boise Cascade Corporation v. Katzenbach, 307 Or 391 (1989); David B. Allen, 43 Van Natta 112 (1991). Accordingly, we vacate that portion of the order which dealt with this issue.

Permanent Total Disability

The Referee concluded that claimant was not permanently and totally disabled as a result of his physical condition or under the odd lot doctrine. In reaching this conclusion, the Referee considered claimant's psychological condition, which she found compensable. As noted above, we find that the issue of the compensability of claimant's psychological condition was not before the Referee. Nevertheless, excluding her consideration of claimant's psychological condition, we adopt the Referee's conclusion and reasoning regarding the issue of permanent total disability with the following supplementation.

In June 1986, a vocational rehabilitation program was cancelled when claimant relocated to Seattle. (Ex. 44). In the closing report, the counselor noted that, although claimant said he was motivated, he delegated all job search duties to the counselor or others. (Ex. 44-2, -3). The counselor also noted that claimant failed to follow through on job opportunities. (Ex. 44-3).

Another vocational rehabilitation program was cancelled in December 1987 because claimant's lack of suitable employment was no longer due to his injury. (Ex. 68-6). The vocational counselor noted that: (1) a position had been secured for claimant but he was unwilling to relocate; (2) claimant focused on securing employment with the state; (3) claimant was unwilling to commute 18-20 miles; and (4) claimant did not follow through on job leads provided to him.

After participating in the Emanuel Pain Center in December 1989, claimant refused to obtain the services of a vocational counselor of his own choosing. (Exs. 109-4, 109-5). The Pain Center psychologist stated that the primary

obstacle to claimant's return to work was his unwillingness to participate in the vocational rehabilitation process. (Ex. 111A).

On this record, we find that claimant is unwilling to enter the work force and that he has not made reasonable efforts to do so. Accordingly, we agree with the Referee that claimant is not entitled to permanent total disability.

Permanent Partial Disability

A May 10, 1984 Opinion and Order awarded claimant 30 percent unscheduled permanent partial disability for his low back injury. (Ex. 32). The Referee awarded claimant an additional 18 percent unscheduled permanent partial disability for a total of 48 percent. Claimant contends that he is entitled to additional unscheduled disability.

SAIF argues that the Referee's impairment rating of 35 percent for the psychological condition should be vacated. We agree. Based on our above reasoning, the issue of the compensability of the psychological was not before the Referee and, as a matter of law, the psychological condition is not compensable.

We adopt the Referee's reasoning and conclusion regarding the values for age (1), formal education (0), training (0), skills (1), and adaptability (6). We address only the impairment value.

We rate disability at the time of the hearing. Gettman v. SAIF, 289 Or 609 (1980). The lumbar range of motion measurements closest to the hearing were normal. (Ex. 118-3). Claimant is entitled to a 5 percent impairment value for a chronic condition limiting repetitive use of his lumbar spine. Former OAR 436-35-320(4). He is entitled to 8 percent for the two chymopapain injections. Former OAR 436-35-350(2). These values are combined for a total impairment value of 13 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 1 is added to his education value 1, the sum is 2. When that value is multiplied by claimant's adaptability value 6, the product is 12. When that value is added to claimant's impairment value 13, the result is 25 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 25 percent.

Because claimant previously received 30 percent unscheduled permanent disability for this low back injury, he is not entitled to an additional amount. Milton Porter, Jr., 43 Van Natta 452, 454 (1991).

Offset

We adopt the Referee's reasoning and conclusions regarding the offset issue.

ORDER

The Referee's order dated February 20, 1991 is reversed in part and affirmed in part. That portion of the Referee's order which found claimant's psychological condition compensable is reversed. That portion of the order that awarded an additional 18 percent (57.6 degrees) unscheduled permanent disability is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
RICHARD D. OLSON, Claimant
WCB Case No. 89-14741
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Phillip L. Nyburg, Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of that portion of Referee Spangler's order that affirmed the Workers' Compensation Division's Order of Dismissal dated February 8, 1991. Specifically, claimant has requested that we set aside the Order of Dismissal and remand this matter to the Division to determine whether claimant is eligible for additional vocational services. In its respondent's brief, the insurer seeks review of those portions of the Referee's order that: (1) increased claimant's unscheduled permanent disability award for a right shoulder injury from 8 percent (25.6 degrees), as awarded by a Determination Order, to 17 percent (54.4 degrees); (2) awarded claimant 5 percent (7.5 degrees) scheduled permanent partial disability for a right hand condition; and (3) authorized the insurer to offset a $2,730.73 overpayment of temporary disability against the increased award of permanent disability. On review, the issues are vocational services, extent of scheduled and unscheduled permanent partial disability, and offset. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Vocational Services

On November 14, 1990, claimant, by and through his attorney, requested the Workers' Compensation Division (Division) to conduct an administrative review of claimant's eligibility for continued vocational rehabilitation services. On November 29, 1990, the Division acknowledged the request and notified claimant's attorney that it intended to resolve the matter directly with claimant unless the attorney objected. Claimant's attorney evidently did not object and, after negotiations, claimant agreed to accept the insurer's offer of $500 in job development services and to withdraw his request for administrative review. Accordingly, the Division issued an Order of Dismissal on February 8, 1991, from which claimant requested a hearing.

ORS 656.283(1) provides that any party may, at any time, request a hearing on any question concerning a claim. However, ORS 656.283(2) limits the scope of the Board's review over decisions by the Division regarding vocational assistance and provides, in pertinent part:

> "The decision of the director may be modified only if it:
>
> "(a) Violates a statute or a rule;
>
> "(b) Exceeds the statutory authority of the agency;
>
> "(c) Was made upon unlawful procedure; or
>
> "(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

Claimant appears to argue that the order was made upon unlawful procedure and argues that he was not represented by an attorney during the settlement negotiations. However, as noted above, the Division expressly notified claimant's attorney as to its intentions to deal directly with claimant. Moreover, there is no evidence that claimant lacked the opportunity to consult with his attorney prior to accepting the agreement. Under those circumstances, we do not consider the order to be legally defective because claimant was not represented by an attorney.

Claimant also argues that the order is not binding until his attorney ratified the settlement agreement. He cites no authority for that proposition, but notes that he did not intend to waive his right to consult with his attorney about the agreement when he participated in the administrative review. We agree that there is no evidence that claimant waived his right to counsel by entering into the informal proceeding. The fact remains, however, that, when claimant agreed to settle the dispute, he was clearly acting in a representative capacity on his own behalf. Moreover, there is no evidence in the record that he was coerced into accepting the insurer's offer of additional vocational services and withdrawing his request for administrative review.

After our review, we agree with the Referee that claimant has failed to establish that the Order of Dismissal violated a statute or a rule, exceeded statutory authority, was made upon unlawful procedure, or constituted an abuse of discretion. Accordingly, we deny claimant's request to set aside the Order of Dismissal and decline to remand the matter to the Director for final determination.

Extent of Permanent Disability

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. Former OAR 436-35-010 through OAR 436-35-260 apply to the rating of claimant's scheduled permanent disability. Former OAR 436-35-270 through OAR 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Unscheduled Disability

The determination of unscheduled 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.

The insurer does not dispute the values assigned by the Referee for claimant's age, impairment, formal education and training. After our review, we adopt those values and address only the issues of skills and adaptability.

Skills

The Referee found that the position with the highest specific vocational preparation (SVP) level that claimant had successfully performed during the past ten years was that of a florist. Therefore, the Referee concluded that the appropriate value for skills was 2. Former OAR 436-35-300(4). On review, the

insurer asserts that the proper skills value is 1, because claimant worked as a carpenter from January 1978 through January 1981. Claimant responds that his work as a carpenter cannot be considered because, although he performed such work within the ten years prior to claim closure, he did not remain on that job the necessary amount of time during those ten years to meet the two to four year vocational preparation requirement.

Former OAR 436-35-300(4) provides, in pertinent part:

> "Skills shall be measured by reviewing the jobs a worker has successfully performed during the ten years preceding the date of determination. Successful performance is defined as remaining on the job the length of time necessary to meet the specific vocational preparation time requirement for that job."

Claimant evidently construes that rule to provide that, for purposes of assigning a skills value under the standards, a worker does not successfully perform a job unless he remains on the job the length of time necessary to meet the vocational preparation requirement during the ten years preceding the date of determination. We do not read the rule so narrowly. There is little dispute that the rule was intended to exclude those jobs a worker had performed but had not remained on the length of time necessary to obtain the appropriate skills. This ensures that the worker's disability is determined upon abilities proven with ten years preceding claim closure. However, we find no reason to interpret the rule to exclude skills successfully demonstrated by the worker during the past ten years simply because some of the time required to develop those skills occurred prior to the ten year period. Accordingly, we conclude that, once a worker has remained on the job the length of time necessary to develop the necessary skills, the only question is whether the worker performed that job during the ten years preceding the date of determination.

In this case, claimant worked as a carpenter from January 1978 through January 1981. As noted by the Referee, that exceeds the SVP time for successful performance of that occupation. Therefore, because claimant successfully demonstrated those skills during the ten years preceding the date of determination, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Adaptability

Finding that claimant was not working at the time of hearing due to his injury, the Referee assigned claimant an adaptability factor from the matrix of values under former OAR 436-35-310(4). On review, the insurer first contends that former OAR 436-35-310(3) properly applies, because claimant had returned to work for his wife. We disagree. Contrary to the insurer's assertion, claimant was not an employee of his wife's day care center. He received no wages, and his assistance was limited to helping his wife make lunches and to washing dishes.

The insurer also contends that former OAR 436-35-310(4) does not apply, because claimant did not leave his last regular employment due to his injury. We disagree. Claimant was terminated from his entry-level accounting job because he had not received adequate vocational training. Because his need for such services arose as a direct result of his compensable injury, the Referee correctly applied former OAR 436-35-310(4) to determine claimant's adaptability under the standards.

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 of 0 is added to his education value 1, the sum is 1. When that value is multiplied by claimant's adaptability value 6, the product is 6. When that value is added to claimant's impairment value 5, the result is 11 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). We add that 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". ORS 656.283(7) and 656.295(5). After our review of the record, however, we find no clear and convincing evidence that the award inadequately compensates claimant for his permanent loss of earning capacity.

Scheduled Disability

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

Offset

The insurer contends, and claimant agrees, that the Referee miscalculated the insurer's overpayment to claimant by $640. Accordingly, in addition to the Referee's authorization, the insurer is authorized to offset against claimant's present and future awards of permanent partial disability the aforementioned $640 overpayment.

Attorney Fee on Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's argument regarding the scheduled permanent disability issue. 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 attorney's services on review is $400, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 6, 1991 is affirmed in part and modified in part. In lieu of the Referee's increased award of unscheduled permanent partial disability, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent partial disability in addition to the 8 percent (25.6 degrees) awarded by a Determination Order, giving him a total unscheduled disability award of 11 percent (35.2 degrees). Claimant's attorney fee for increased compensation shall be adjusted accordingly. The insurer is authorized to offset its $640 overpayment against claimant's present and future awards, if any, of permanent disability. The remainder of the order is affirmed. For services on Board review regarding the scheduled permanent disability issue, claimant's attorney is awarded a reasonable fee of $400, to be paid by the insurer.

In the Matter of the Compensation of
IDELLA E. VANCE, Claimant
WCB Case No. 90-01341
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court reversed our prior order which found claimant's occupational disease claim for a bilateral carpal syndrome condition compensable because she had established that her work activities were a material contributing cause of her condition. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's August 16, 1990 order with the following exception. For the past year preceding her October 1989 examination with Dr. Robertson, claimant had not been taking her hypothyroid medication.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we found that claimant's work activities as a nurse's aide were a material contributing cause of her bilateral carpal tunnel syndrome condition. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that such a finding established the compensability of her occupational disease claim. Consequently, we affirmed the Referee's order which had set aside the insurer's denial.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that her work activities were the major contributing cause of her condition or the worsening of her underlying condition. Aetna Casualty co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of her condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (1992).

In our prior order, we adopted the Referee's reasoning for relying on the opinion of Dr. Robertson, claimant's treating orthopedist, rather than Dr. Jewell, independent medical examiner. On further consideration, in light of the physician's familiarity with both claimant's condition as well as her medical and work history, we continue to find the observations rendered by Dr. Robertson to be more persuasive than those offered by Dr. Jewell. See Weiland v. SAIF, 64 Or App 810 (1983). In addition, we consider Dr. Robertson's opinion concerning the relationship between claimant's work activities and her bilateral carpal tunnel syndrome condition to be more thorough and well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Robertson disagreed with Dr. Jewell's opinion that claimant's bilateral carpal tunnel syndrome condition is idiopathic in nature and unrelated to her work activities. In doing so, Robertson acknowledged the existence of claimant's hypothyroid condition (which he had previously described using such terms as "significant" and "severely") and the fact that hypothyroidism can aggravate

the carpal tunnels. However, Robertson explained that the hypothyroid condition effects the median nerve "from two sources, one a peripheral neuropathy, the second due to myxedema tissue in the wrist." (Ex 7-2). Noting that there was no evidence of myxedema tissue in the wrists and that nerve conduction studies were not characteristic of a peripheral neuropathy, Dr. Robertson concluded that claimant's bilateral carpal tunnel syndrome condition was related to her work activities.

Admittedly, Dr. Robertson does not expressly conclude that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome condition. Nevertheless, to be sufficient to establish the compensability of a claim, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" not required). Inasmuch as Dr. Robertson persuasively explained why claimant's hypothyroid condition did not cause her bilateral carpal tunnel syndrome condition and conclusively related claimant's bilateral carpal tunnel syndrome condition to her work activities, we hold that claimant has established that her occupational disease claim is compensable under former ORS 656.802.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 24, 1991 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUDITH E. AINSWORTH, Claimant
WCB Case Nos. 90-02215 & 90-15488
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys
Rudolph Harris (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

Crawford and Company (Crawford) requests review of those portions of Referee Peterson's order that: (1) set aside its denial of responsibility for claimant's "new injury" claim for a low back condition; and (2) upheld the SAIF Corporation's denial of responsibility for claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACTS" with the following supplementation.

The October 16, 1989 incident with Crawford's insured was a material contributing cause of claimant's subsequent disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the law in effect before the amendments by Oregon Laws 1990 (Special Session), chapter 2 (hereinafter called the "1990 Act"). Citing Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986), the Referee found that claimant's employment with Crawford's insured independently contributed to a worsening of his low back condition, and concluded that Crawford is responsible

for that condition. We agree with the Referee's conclusion, but rely on the following reasoning.

We must first determine whether the 1990 Act applies to this case. Claimant requested a hearing after May 1, 1990. Therefore, the litigation savings clause contained in section 54(2) of the 1990 Act does not apply. Additionally, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See, e.g., 1990 Act, 54(3). Moreover, application of the 1990 Act will not produce an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. See Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the 1990 Act.

Section 49(1) of the 1990 Act provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

We have interpreted section 49(1) to mean that, in cases in which an accepted injury is followed by an increase in disability during employment with a later insurer, responsibility rests with the original insurer unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991). Therefore, SAIF, as the last insurer against whom claimant had an accepted low back injury, remains presumptively responsible. In order to shift responsibility, SAIF has the burden of proving that claimant sustained a new compensable injury involving the same condition while working for Crawford's insured.

In order to prove a new compensable injury, SAIF must show that the October 16, 1989 incident with Crawford's insured was a material contributing cause of claimant's disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a), 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

On October 16, 1989, while working for Crawford's insured, claimant was squatting and changing shelves in a refrigerator when she felt sharp pain radiating through the left leg to the ankle. That day, she saw Dr. Rogachevsky, chiropractor, who reported low back and left leg pain and observed that claimant walked leaning to the right. He took her off work and diagnosed lumbar sprain/strain. (Ex. 20). During the next few days, claimant developed pain in the right leg extending to the foot. Her symptoms improved with treatment.

Dr. Rogachevsky opined that claimant sustained an "independent" injury as a result of the October 16, 1989 incident. He noted that, whereas claimant appeared to reach a stationary level and was "nearly asymptomatic" before the 1989 incident, after that incident, she had more pain and required a prolonged recovery period. (Exs. 26, 27D). He also opined that the 1989 incident was the major contributing cause of claimant's disability and need for treatment since that date. (Ex. 27D).

Dr. Duncan, a chiropractor, performed an independent medical examination on January 4, 1990. He attributed most of claimant's back complaints to obese malposture and underlying degenerative joint disease. Although he conceded that

her discomfort was "transitorally aggravated by postural stressors" on October 16, 1989, he did not believe that incident was sufficient to cause an actual injury to the back or to materially affect the underlying degenerative condition. (Ex 27).

After reviewing the medical record, we are most persuaded by Dr. Rogachevsky's opinion. As claimant's treating physician since 1988, he is the only medical expert that had the opportunity to observe and evaluate claimant's condition before and after the 1989 incident. See Jordan v. SAIF, 86 Or App 29, 33 (1987); Weiland v. SAIF, 64 Or App 810, 814 (1983). Dr. Duncan, on the other hand, only examined claimant once, more than three months after the 1989 incident.

Additionally, Dr. Rogachevsky's opinion is supported by the record, which shows that claimant's need for treatment immediately before the 1989 incident had diminished to one treatment in two months. (Ex. 16-13). Based on Rogachevsky's opinion, we find that the 1989 incident was at least a material contributing cause of claimant's subsequent disability and need for treatment. Contrary to Dr. Duncan's apparent belief, the evidence need not establish a material worsening of her accepted condition. See Rosalie S. Drews, 44 Van Natta 36 (1992). Furthermore, based on Rogachevsky's findings and diagnoses, we find that the injury is established by medical evidence supported by objective findings. Accordingly, SAIF has sustained its burden of proving a new injury, for which Crawford is responsible under Section 49(1) of the 1990 Act.

ORDER

The Referee's order dated January 4, 1991 is affirmed.

March 13, 1992 Cite as 44 Van Natta 447 (1992)

In the Matter of the Compensation of
DOUGLAS K. BATEMAN, Claimant
Own Motion No. 92-0069M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for an alleged worsening of his September 14, 1980 compensable right knee injury. Claimant's aggravation rights expired on January 28, 1988. SAIF has accepted the compensability of a proposed right knee arthroscopic surgery and recommends that we authorize the payment of temporary disability compensation. SAIF also requests that we authorize reimbursement from the Reopened Claims Reserve.

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

Dr. Weinman opines that claimant has a tear of the right knee medial meniscus resulting from his 1980 injury. (Report of July 30, 1991). Dr. Weinman has requested authorization of arthroscopic surgery for the right knee from SAIF. (Chart note of December 5, 1991). Thus, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation

beginning the date he is hospitalized for the proposed surgery. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

Claimant also injured his left knee in 1991 when another carrier was on the risk. The left knee requires arthroscopic surgery. Dr. Weinman plans to perform both the right and left knee surgeries at the same time. (Chart note of December 5, 1991). Thus, claimant may have an accepted, open claim with another carrier for the injury to his left knee at the same time this claim is in open status. Claimant is not entitled to receive double the statutory sum of benefits for the same period of temporary disability. If concurrent benefits for temporary disability are due claimant as a result of these claims, the benefits shall be paid in the same manner as set out in accordance with OAR 436-60-020(7) and (8). See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). If the insurers for the separate claims request approval from the Compliance Division to prorate benefits, this order is notice that we consent to the payment ordered by the Compliance Division.

Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA L. CARROLL, Claimant
WCB Case No. 90-00769
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gunn and Moller.

Claimant requests review of Referee Livesley's order that upheld the insurer's denials of claimant's right carpal tunnel syndrome (CTS) condition, left wrist condition, and right shoulder condition. On review, the issues are compensability of the aforementioned conditions. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following corrections and supplementation. Claimant's right carpal tunnel release was performed on December 8, 1989. She was released to regular work without restrictions in February 1990.

Claimant's work duties as a utility clerk over the last five-and-a-half years included stamping checks daily for endorsement. This activity ranged from a minimum of 20 minutes per day to a maximum of one hour per day. This maximum period occurred for five to ten days per month.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing before May 1, 1990 and a hearing was convened before July 1, 1990, her claim is properly analyzed under the law in effect prior to the 1990 revisions to the Workers' Compensation Act. Or Laws 1990, Special Session, Ch. 2, 54.

To establish the compensability of her right carpal tunnel syndrome (CTS), right shoulder condition, and left wrist condition under former ORS 656.802(1)(c), claimant must prove, by a preponderance of the evidence, that employment activities in the form of a series of traumatic events or occurrences were the major contributing cause of these conditions, requiring medical services or resulting in disability. See Aetna Casualty Co. v. Aschbacher, supra. Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983).

We find that the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Right Carpal Tunnel Syndrome

The chart notes of Dr. Reeves, claimant's family physician, list five separate falls; however, none of the falls resulted in trauma to the wrists. Dr. Reeves found it more probable that the CTS was brought about by the work activities rather than the superficial fall injuries. However, Dr. Reeves did not discuss claimant's work activities with her, and he deferred to Dr. Jones, treating orthopedist, on the issue of causation. (Exs. 10-13, 10-19).

Dr. Jones noted that CTS can result from trauma caused by a fall but he noted that, in that case, CTS symptoms would develop immediately or within days. (Ex. 9-8). The record indicates that claimant's symptoms developed gradually over a couple of years. Furthermore, nothing in the record indicates that claimant injured her wrists in these falls or that she developed CTS symptoms as a result of these falls.

Dr. Button, orthopedist, conducted a record review for the insurer and opined that claimant's work activities were not causative or materially aggravating regarding the CTS. (Ex. 4-1). He tentatively opined that the cause was idiopathic. Id. Dr. Button did not meet with claimant and had no demonstration of the use of the endorsement stamps. In addition, he had an inaccurate history regarding claimant's work activities. He understood that the work involved endorsing checks from 20 minutes to an hour for only five to ten days a month. Id. Actually, claimant endorse-stamped checks on a daily basis at a minimum of 20 minutes per day. For five to ten days per month, this activity lasted a maximum of an hour per day. Because Dr. Button had an inaccurate history, we do not find his opinion persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, 64 Or App 810 (1983).

Dr. Jones, treating orthopedist, performed claimant's right carpal tunnel surgery, knew claimant, and questioned her about her work and nonwork activities. (Ex. 7). He opined that direct trauma to the wrist and palm area rather than repetitive motion of the wrist would be a direct cause of CTS. Claimant demonstrated use of the four endorsement stamps she had used over a five-and-a-half year period. Dr. Jones found that, of the four stamps, the last three used resulted in varying degrees of trauma to the palm and wrist. It was while using these three stamps that claimant's condition appeared and worsened. Dr. Jones opined that the major contributing cause of her CTS was the check stamping activities which caused trauma to claimant's palm and wrist. (Ex. 9-17). He also opined that it was medically probable that using the hand stamps caused claimant's CTS, given the fact that she had no activities outside of work that would produce the same trauma. (Exs. 7, 9-30).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there are no persuasive reasons not to defer to Dr. Jones. Although the questioning during his depositions created some indecision, we find that he ultimately came to the conclusion that claimant's work activities were the major contributing cause of her right CTS. Thus, we conclude that claimant has established, by a preponderance of the evidence, that her work activities were the major contributing cause of her right CTS.

Right Shoulder Condition

The medical evidence does not establish that claimant's work activities are the major contributing cause of her right shoulder condition. Dr. Reeves opined that there was no indication that the shoulder condition was work-related. (Exs. 10-4, 10-15). Dr. Jones opined that claimant suffered from subacromial bursitis that might be related to a fall as opposed to a hand-shoulder syndrome. (Exs. 8-8, 9-12, 9-18). He did not relate the shoulder condition to claimant's work activities. On this record, we find that claimant has failed to establish that her work activities are the major contributing cause of her right shoulder condition.

Left Wrist Condition

There is very little medical evidence in the record relating to claimant's left wrist condition. Regarding the relationship with claimant's work activities, Dr. Jones opined that only the check stamping activity could have caused wrist problems. However, claimant did this activity with her right hand. As for her left wrist condition, Dr. Jones noted that the nerve conduction studies showed borderline CTS on the left. (Ex. 2A-2). He tentatively classified the left wrist condition as being secondary to overuse type activity. Id.

Dr. Reeves did not give an opinion about the left wrist condition. We find that Dr. Jones' statements are not sufficient to establish that claimant's work activities were the major contributing cause of her left wrist condition.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of the right CTS condition. 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 attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of the right CTS condition is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 18, 1991 is reversed in part and affirmed in part. The insurer's denial of the right carpal tunnel syndrome condition is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning compensability of claimant's right CTS condition, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
ROY HANSEN, Claimant
Own Motion No. 66-0200M
OWN MOTION ORDER
Emerson G. Fisher, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for the provision of additional medical benefits related to his May 29, 1959 claim. Claimant was awarded permanent total disability benefits in 1966. The claim was last closed on November 13, 1990. SAIF then recommended that the claim be reopened for the provision of medical services, specifically to provide prescriptions, an office visit and an x-ray. SAIF also requested reimbursement from the Reopened Claims Reserve.

Prescriptions from September 25, 1990 through January 5, 1991 included 2,250 Darvon (65 mg) in the amount of $676.90; 345 Valium (10 mg) in the amount of $369.85; 1500 Lomotil in the amount of $597; 1,500 ProBanthine (15 mg.) in the amount of $849.85; 60 Annaprox in the amount of $83.95; and Preparation H in the amount of $58.00. By a January 30, 1991 Own Motion Order, we authorized reimbursement for the office visit and x-ray, but deferred further action on claimant's request for the authorization of prescription medications until an inpatient evaluation of the reasonableness and necessity of the unusually high dosage of medications prescribed by Dr. Birkelo, claimant's treating physician, had been performed at the University of Washington Medical School, Oregon Health Sciences University or any other comparable medical facility. Specifically, we requested an opinion regarding claimant's alleged malabsorption syndrome and the need for medications at the levels prescribed.

Claimant requested a hearing to obtain further information regarding the inpatient evaluation and suggested that he may not be able to tolerate the evaluation. By a February 14, 1990 Own Motion Order, we declined to refer the matter for an evidentiary hearing and directed claimant to seek further information regarding the evaluation from the medical facility where SAIF had scheduled the evaluation. We also suggested that claimant submit a doctor's opinion to the Board if he felt he could not tolerate the evaluation.

Claimant then contended that the Board does not have own motion jurisdiction over his request for medical benefits and requested that we remand the matter to SAIF for processing under ORS 656.245. By an April 4, 1991 Own Motion Order, we abated our prior order to permit reconsideration of the jurisdictional issue.

By an April 24, 1991 Own Motion Order, we established that the Board has subject-matter jurisdiction under its own motion to review pre-1966 injury claims for medical benefits and proceeded to republish our February 14, 1991 order.

On April 19, 1991, SAIF submitted additional billings for prescriptions, lodging and an office visit. The prescriptions, administered from January 24, 1991 through March 30, 1991, included 2,250 Darvon (65 mg.) in the amount of $689.85; 345 Valium (10 mg.) in the amount of $389.85; 1,500 ProBanthine (15 mg.) in the amount of $899.85; 1,500 Lomotil in the amount of $597.00; and Preparation H in the amount of $58.50.

On November 21, 1991, we received a copy of claimant's medical file, which had been sent by SAIF to the Medical Review and Abuse Section of the Workers Compensation Division requesting that the Director determine the reasonableness and necessity of the amount of narcotic medication being consumed by claimant.

This file included an independent medical examination performed on an outpatient basis by Dr. Schaer, M.D., at the Gastroenterological Clinic, Oregon Health Sciences University, on June 11, 1991. Dr. Schaer was unable on the basis of a single outpatient visit to make either a determination regarding the etiology of claimant's chronic diarrhea or whether his medication intake was reasonable. He stated, "To accurately evaluate [claimant], I believe he will need to be placed in a controlled setting, taken off his medications and repeat evaluations done." In other words, Dr. Schaer recommended the same type of controlled, inpatient evaluation we had ordered in our February 14, 1991 Own Motion Order.

FACTS

Claimant, 62 years old, sustained a crushing injury to his low back, pelvis, abdomen and feet when he was struck by falling boulders. His intestine was avulsed and became infected, requiring a bowel resection. (Ex. 206). In September 1962, Dr. Gray examined claimant after claimant continued to have diarrhea that was not amenable to control by anticholinergics and a bland diet. Dr. Gray performed tests to rule out a malabsorption syndrome, and concluded that, on the basis of claimant's history, physical findings, and laboratory results, claimant's intestinal distress was the result of hypoirritability and hypermotility. (Exs. 199, 200).

In a May 11, 1966 report, Dr. Chuinard, orthopedist, recommended that only one doctor should provide claimant with pain medication, in order to prevent overmedication with tranquilizers, sleeping pills, and so forth. (Ex. 186). In August, 1967, claimant was referred to Dr. Bittner by SIAC (SAIF's predecessor) for an inpatient evaluation in an effort to get him off the large number of drugs that he had been taking. After tests, Dr. Bittner also ruled out malabsorption syndrome, diagnosing claimant's bowel condition as functional bowel syndrome, probable multiple abdominal adhesions secondary to old abscesses, fusion of the right hip, and arthritis of the lumbar spine, L3-4-5. He reported,

> "The patient was gradually withdrawn from medication and at the time of discharge was taking only Norgesic, two 2 or 3 times a day and Lomotil two tablets between once and two times a day. His stools had decreased from a number of five to ten per day to a form stool occurring two or three times a day, with little or no cramping. [After psychologic testing and evaluation] [i]t was felt that his problem was primarily that of drug dependency." (Ex. 182, 183, 184).

In October 1967, claimant was again admitted to the hospital for overdosing on medication. Dr. Gray evaluated claimant after noting that claimant had been taking an inordinate number and variety of drugs prescribed by various physicians throughout the state of Oregon, which included sedatives, tranquilizers, muscle relaxants, analgesics, and anticholinergic drugs for his bowel difficulties. Gray stated that claimant had no absorptive defect, but a problem of hypermotility. Gray based his opinion on stool analysis and the fact that claimant's general nutrition was good. Gray agreed that tranquilizers and sedatives should not be a responsibility of the State Compensation Department, but he did recommend that claimant take Darvon 65, Lomotil and Probanthine. He noted that, while in the hospital, divided daily doses of Lomotil and Probanthine enabled claimant to control his diarrhea. Gray did not indicate the prescription amounts of these drugs. (Ex. 180, 181).

In November 1967, the State Compensation Department agreed to compensate McAlear Pharmacy in Twin Bridges, Montana, for medication related to the treatment of claimant's industrial accident. (Ex. 178). In January 1974, SAIF wrote to the pharmacy, discontinuing responsibility for any further prescriptions

because they did not know the whereabouts of claimant's doctor, Dr. Beithon. (Ex. 175). In January 1977, claimant consulted Dr. Jacobson, who gave claimant prescriptions for Lomotil, Probanthine, Valium and Darvon 65 at the rate of 4 a day. Dr. Jacobson reported claimant was very upset and stated he could not get by on less than 500 per month. Jacobson refused to prescibe that dosage. (Ex. 157). Apparently, payments continued to be made to McAlear Pharmacy, because SAIF again, in July 1977, stated it could not continue payment of bills without current medical reports. Claimant had not seen Dr. Beithon since August, 1975. (Ex. 158). In November 1977, SAIF's medical director reported that claimant had been getting each month, as prescribed by Dr. Beithon, the following: 450 Lomotil (15 per day); 100 Valium (3 per day); 550 Darvon 65 (18 per day); and 400 Probanthine (13 per day). (Ex. 154). Dr. Beithon replied to this report, stating that he thought claimant may be addicted to Lomotil. Dr. Beithon stated he was not aware that claimant was taking as much medication as listed, stating he had not seen claimant since August of 1975 until August 1977. (Ex. 153). In January 1978, claimant was sent to Dr. Jacobson for evaluation. Claimant left with prescriptions for 120 each of Darvon, Valium, Probanthine, and Lomotil. (Ex. 150). On February 1978, Dr. Jacobson refused to continue to see claimant after claimant indicated his noncooperation with management of medication. (Ex. 146). Upon this refusal, SAIF reauthorized Dr. Beithon to be the sole provider of claimant's treatment and medication. (Ex. 145). At this time, claimant weighed 210 pounds. Dr. Beithon reported to SAIF three visits by claimant wanting new prescriptions for increased amounts of Valium, Darvon, Lomotil, Probanthine, and Preparation H. (Ex. 142). After an appearance before the Montana Board of Medical Examiners, Dr. Beithon withdrew as claimant's acting physician. (Ex. 141). Claimant requested a hearing on the reduction in the amounts of drugs he had been receiving. (Ex. 139).

In September 1978, Dr. Gray stated to claimant's attorney that claimant's drugs were indicated on clinical grounds because claimant continued to suffer from either malabsorption or fistulae related to his original injuries. (Ex. 138). In October 1978, Dr. Canty reported to SAIF that claimant's hip replacement was excellent and that his discomfort had decreased. He noted that, despite this improvement, claimant continued to take large amounts of medication, including Valium, Darvon 65, Probanthine and Lomotil. (Ex. 137). In February 1979, Dr. Gray resigned as claimant's physician. (Ex. 135). In May 1979, Dr. Gray was reprimanded by the Oregon Board of Medical Examiners for overprescribing medication to claimant. (Ex. 132).

In September 1979, claimant consulted Dr. Staples, M.D. for prescription refills. (Ex. 134). In November 1980, Dr. Staples resigned as claimant's physician. In May 1981, SAIF's medical consultant, Dr. Norton, wrote to the Montana State Board of Medical Examiners, noting that a Dr. Birkelo in Butte, Montana, was cooperating with claimant to obtain medication in large quantities. (Ex. 124). The Montana Board recommended that prescriptions for claimant be written new every three months, that claimant may have only one month's supply of medicine at a time, and that Dr. Birkelo was to evaluate claimant every three months. (Ex. 120). Dr. Davidson, who examined claimant in March 1986, recommended another hip surgery and noted that claimant had become addicted to many of his medications. (Ex. 81). In August 1986, Dr. Birkelo wrote to SAIF that he was uncomfortable writing prescriptions for claimant, but that there was not much he could do to reduce the amount of medication unless claimant was willing to embark on a prolonged program of gradual reduction, in which claimant showed no interest. Birkelo recommended that claimant be sent to a medical center for evaluation and advice in management of his problem. (Ex. 68). By the January 19, 1989 Stipulation, SAIF agreed to assume responsibility for related medical expenses, including medication, from September 1977 to the date of the stipulation. (Ex. 136).

Dr. Norton, SAIF's medical advisor, reviewed claimant's file for an opinion regarding claimant's drug use. He contacted Dr. Birkelo for an explanation of his prescription of massive amounts of drugs. Dr. Birkelo replied that claimant had been diagnosed with a malabsorption syndrome which he stated was diagnosed by physicians in Seattle. According to Dr. Norton's records, there was no reported medical evidence of malabsorption on stool examination, endoscopy or bowel biopsy. Thus, Dr. Norton was unable to validate a diagnosis of malabsorption bowel syndrome from the medical records.

Dr. Birkelo reported that he had been before the Montana Board of Medical Examiners and was given permission to continue prescribing. He also stated that he was uncomfortable prescribing, and welcomed an evaluation of claimant's need for these medications. (Report of December 13, 1990).

CONCLUSION

After our review of this record, we ordered the inpatient evaluation of the relationship of claimant's alleged malabsorption condition to his compensable injury and an evaluation of the kind and amounts of drugs that were being prescribed for this condition. Claimant underwent a brief outpatient evaluation, rather than the definitive evaluation that we ordered. We are unable to determine from the examination report that claimant experiences a malabsorption syndrome related to his compensable injury. More importantly, we are unable to determine what medications and what dosages are reasonable and necessary for the sequelae of his industrial injury. Thus, the evidence fails to prove that the type or amounts of medication are reasonable and necessary for the treatment of claimant's compensable condition. We, therefore, deny claimant's claim for these medications and decline to authorize reimbursement from the Reopened Claims Reserve.

IT IS SO ORDERED.

March 16, 1992 Cite as 44 Van Natta 454 (1992)

In the Matter of the Compensation of
RICK S. BAYOUTH, Claimant
WCB Case No. 90-04701
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of those portions of Referee Brown's order that: (1) upheld the insurer's denial of claimant's medical services claim for proliferant injection therapy; and (2) upheld the insurer's "de facto" denial of claimant's medical services claim for low back surgery. On review, the issue is medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

On May 26, 1988, claimant injured his low back while employed as a substitute physical education teacher. He initially sought physical therapy from a sports medicine clinic and received ice therapy, massage and light traction for a period of approximately two weeks. On June 13, 1988, he was examined by Dr. Maurer, who diagnosed a lumbosacral sprain and continued to provide conservative treatment.

Claimant's pain continued and he was referred to a chiropractor for mobilization, which proved unsuccessful. Claimant was then referred to Dr. Dunn, a neurosurgeon, who diagnosed facet syndrome with bilateral ligamentous strain. Dr. Dunn did not believe surgical intervention was necessary at that time and recommended further physical therapy.

Dr. Dunn referred claimant to Dr. Delong, for consultation. Dr. Delong diagnosed claimant's condition as intervertebrable disc derangement and believed that he would benefit from proliferant injection therapy. The insurer denied the proposed treatment by letter dated January 5, 1990.

After a period of improvement, claimant returned to Dr. Dunn on May 22, 1990, with complaints of increased pain. Dr. Dunn referred claimant back to Dr. Delong for workup and possible surgical intervention.

On June 28, 1990, claimant was examined by Dr. Dickerman, a neurologist, and Dr. Donahoo, an orthopedic surgeon, at the offices of the Orthopaedic Consultants. Both doctors noted functional overlay and concluded that claimant should not have any type of surgery performed on his back.

Claimant's claim was closed by an August 29, 1990 Determination Order, which awarded periods of temporary disability and 11 percent unscheduled permanent partial disability.

Meanwhile, Dr. Delong referred claimant to Dr. White and Dr. Schofferman, who, on August 31, 1990, requested authorization to perform a L5-S1 laminectomy and discectomy and endplate decortication without fusion. Dr. White ultimately performed the low back surgery in January 1991.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

Claimant requested a hearing in this matter before May 1, 1990, and the hearing was convened on June 25, 1990. Accordingly, we analyze this matter pursuant to the law in effect prior to July 1, 1990. Or Laws 1990 (Special Session), ch. 2, 54(2); John K. French, 43 Van Natta 836 (1991).

Medical Services--Proliferant Injection Therapy

The Referee concluded that the proliferant injection therapy was not a compensable medical service because claimant had failed to obtain prior authorization for the treatment as required by OAR 436-10-040(9). Claimant contends that such authorization was sought and relies on a chart note written by Dr. Dunn, the treating physician, which provides:

> "I do believe that [claimant] would respond to proliferant injections as suggested by Dr. Delong and this will be arranged after he has two trial session without proliferance without manipulation. I anticipate this should take a total of six weeks before a final evaluation can be made." (Ex. 49-3).

We agree that the chart note provided the insurer with notice that Dr. Dunn intended to treat claimant with proliferant injections. We do not, however, consider the chart note a request for authorization for such therapy. Moreover, OAR 436-10-040(11) specifically requires that a request for prolotherapy must be submitted to the insurer on the Department of Insurance and Finance Form 2000. Given the nature of the treatment, we consider this filing requirement to be a reasonable procedure for determining whether such treatment is reasonable and necessary. Rager v. EBI Companies, 107 Or App 22 (1991).

Accordingly, we do not consider the chart note a sufficient request for authorization under OAR 436-10-040(9). The Referee's decision is affirmed.

Medical Services--Low Back Surgery

The Referee concluded that the recommended surgery was not a compensable medical service, because it was not reasonable and necessary for the treatment of claimant's low back injury. We disagree.

For his compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of recovery requires." Former ORS 656.245(1). In order to prove the compensability of the proposed low back surgery, claimant has the burden of proving, by a preponderance of evidence, that the requested surgery is reasonable and necessary. West v. SAIF, 74 Or App 317 (1985).

Claimant primarily relies on the opinions of Dr. White and Dr. Schofferman. Dr. White, who performed the low back surgery in January 1991, reported that claimant suffered from painful disc disease and possible herniations at multiple levels of the spine. He explained that surgery was required to give claimant some relief of his painful symptoms caused by those conditions and to enable claimant to return to his normal activities. Dr. Schofferman agreed that claimant was a good candidate for the surgery. He believed that the compensable low back injury had worsened claimant's degenerative disc disease to the extent that he required medical care and that claimant had a 60 to 70 percent chance that the surgery would improve his pain level by 50 percent.

The insurer contends that neither physician's opinion is persuasive, because they are based solely upon claimant's unreliable subjective complaints of pain. We disagree. First, contrary to the insurer's allegation, claimant's need for surgery was supported by objective findings. In the request for surgical authorization, Dr. White reported that CT scans taken in August 1990 revealed posterior herniation at L5-S1, degenerative changes at L3-4 and L4-5. He also reported that a MRI scan demonstrated significant degeneration at all three levels. Moreover, Dr. Schofferman reported that, in his opinion, claimant's subjective complaints were consistent with those objective findings. Second, Dr. Dickerman and Dr. Donahoo's opinion, which concluded that claimant was not a good surgical candidate due to the lack of objective findings, was rendered prior to the date of those additional diagnostic studies. Because their opinion is based on incomplete information, we do not find it persuasive and accord it little weight. Somers v. SAIF, 77 Or App 259 (1986). Finally, after an objective evaluation of claimant's testimony and the medical record, we find no evidence that casts doubt on the reliability of his complaints of pain. Throughout the recovery of his low back injury, claimant has been extremely motivated to alleviate his pain and discomfort. His efforts include seeking physical therapy prior to filing a claim for compensation. We are not persuaded by the surveillance films which document 23 minutes of physical activity during more than seven hours of observation. The filmed activities are consistent with Dr. Dunn's depositional testimony that claimant would be able to perform coaching activities on a limited basis.

After our review of the record, we conclude that claimant has established that the low back surgery was reasonable and necessary medical treatment for his compensable low back injury. Accordingly, the insurer's "de facto" denial is set aside.

Attorney Fee at Hearing and on Board Review

Because claimant has prevailed against a denial of compensation, claimant's counsel is entitled to an assessed fee under 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 attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of the low back surgery is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 4, 1991, as reconsidered on April 16, 1991, is affirmed in part and reversed in part. The insurer's "de facto" denial of claimant's medical services claim is set aside and the claim is remanded to the insurer for further processing according to law. For prevailing on review concerning the "de facto" denial, claimant's counsel is awarded a reasonable attorney fee of $2,000, to be paid by the insurer. The remainder of the order is affirmed.

March 16, 1992 Cite as 44 Van Natta 457 (1992)

In the Matter of the Compensation of
DALANI L. GRAY, Claimant
WCB Case No. 89-16644
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Leahy's order that awarded an assessed attorney fee of $2,500 for claimant's attorney's efforts in setting aside the denial of a right wrist condition and a penalty-related attorney fee of $500 for SAIF's late denial. On review, the issue is attorney fees.

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

On January 5, 1990, the Referee issued an order which: (1) set aside SAIF's July 10, 1989 denial of claimant's right wrist condition; (2) awarded an assessed fee of $1,200 for claimant's attorney's services at hearing in overturning the denial; and (3) awarded a penalty-related assessed fee of $500 for SAIF's late denial. On December 5, 1990, the Board vacated this order on an evidentiary issue and remanded the case to the Referee. On March 5, 1991, a second hearing was held. On July 12, 1991, the Referee issued an order in which he cured the evidentiary problem, found claimant's wrist condition compensable, and assessed attorney fees. The Referee's order stated that: (1) the "vacated January 5, 1990 Opinion is reinstated and republished as Exhibit 'A' to this Opinion and Order" (emphasis added); (2) SAIF's July 10, 1989 denial is set aside; and (3) claimant's attorney is awarded an assessed fee of $2,500 for overturning the denial and $500 for the late denial.

On review, SAIF argues that the Referee awarded separate assessed attorney fees and penalty-related attorney fees for each hearing. SAIF argues that the Referee's total award was $3,700 in assessed fees and $1,000 in penalty-related fees. SAIF contends that this award is excessive. Claimant responds that the Referee awarded: (1) a total assessed attorney fee of $2,500 which compensated claimant's attorney for his services at both hearings for prevailing on the denial; and (2) a total penalty-related assessed attorney fee of $500 for SAIF's late denial.

We agree with claimant. Because the first order was vacated, only the second order has any effect. As noted above, the Referee only incorporated the opinion portion of the vacated order into his second order. Thus, there was only one order issued. Accordingly, the total assessed attorney fee for services at hearing is $2,500, and the total penalty-related assessed attorney fee for SAIF's late denial is $500.

We note that, inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the Referee's attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Benjamin G. Parker, 42 Van Natta 2476 (1990).

ORDER

The Referee's order dated July 12, 1991 is affirmed.

In the Matter of the Compensation of
SAM L. HOOVER, Claimant
WCB Case No. 90-06155
ORDER ON REMAND
Gatti, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Hoover v. SAIF, 110 Or App 140 (1991). Our prior order affirmed and adopted that portion of the Referee's order that declined to award an assessed attorney fee for services regarding the SAIF Corporation's pre-hearing rescission of its denial under former ORS 656.386(1). The court has reversed and remanded after SAIF conceded that claimant was entitled to a reasonable attorney fee in light of Jones v. OSCI, 108 Or App 230 (1991).

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On March 20, 1990, claimant's attorney requested a hearing concerning SAIF's March 12, 1990 denial of claimant's thoracic back injury claim. SAIF had denied the claim because claimant had not sought medical treatment. On April 6, 1990, claimant's attorney requested a report from Dr. Warner, claimant's treating chiropractor, regarding claimant's condition and its relationship to claimant's work activities. SAIF rescinded its March 12, 1990 denial on April 16, 1990. SAIF reported that it had received information from claimant's treating physician indicating that claimant had sought medical treatment. The hearing in this matter was initially convened on June 25, 1990 and was continued and reconvened on July 31, 1990.

On July 18, 1990, Dr. Warner responded to claimant's attorney's request for a report. Warner concluded that claimant's treatment was related to a work incident. On July 20, 1990, claimant's attorney referred Dr. Warner's report to SAIF.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not entitled to an assessed attorney fee under former ORS 656.386(1). The Referee relied on our order in Duane L. Jones, 42 Van Natta 875 (1990), which held that former ORS 656.386(1) provided

no basis for an award of insurer-paid attorney fees to a claimant when a carrier withdraws its denial prior to hearing. We affirmed and adopted the order of the Referee.

Our order in Jones initially was affirmed by the Court of Appeals. Jones v. OSCI, 107 Or App 78 (1991). The court subsequently allowed reconsideration, however, and withdrew its opinion. Jones v. OSCI, 108 Or App 230, 232 (1991). The court's action was based on the 1991 amendment to ORS 656.386(1) providing that if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Id. Relying on its decision in Jones, the court has reversed and remanded for reconsideration of claimant's attorney fee award.

Considering that claimant's attorney submitted a March 20, 1990 hearing request regarding SAIF's March 12, 1990 denial and sought a medical report from Dr. Warner, and in light of SAIF's April 16, 1990 rescission and acceptance of claimant's claim prior to the scheduled hearing, we conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. See Kimberly Wayne, 44 Van Natta 328 (1992). Consequently, claimant is entitled to an attorney fee award under ORS 656.386(1). Jones v. OSCI, supra.

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we find that a reasonable attorney fee concerning the pre-hearing rescission of SAIF's denial is $750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the value of the interest involved, and the risk that claimant's attorney's efforts might go uncompensated. We further note that claimant's attorney has already received a $800 fee for an unreasonable denial. Finally, claimant's attorney's services rendered subsequent to SAIF's April 16, 1990 rescission have not been considered.

Accordingly, on reconsideration, that portion of the Referee's order which declined to award claimant an attorney fee under former ORS 656.386(1) is reversed. Claimant's attorney is awarded a reasonable attorney fee of $750, for services concerning the rescission of SAIF's denial, to be paid by the SAIF Corporation. The Referee's $800 attorney fee award concerning SAIF's unreasonable denial remains unaffected by this decision.

IT IS SO ORDERED.

March 16, 1992 Cite as 44 Van Natta 459 (1992)

In the Matter of the Compensation of
JOHN G. MADSEN, Claimant
WCB Case No. 89-03035
ORDER ON REMAND
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Gathman v. Madsen, 108 Or App 364 (1991). The court reversed our prior order which found claimant's occupational disease claim for a low back condition compensable because he had established that his work activities were a material contributing cause of his increased low back symptoms. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's June 26, 1989 order with the following supplementation. Claimant's work activities were not the major contributing cause of a worsening of his underlying low back condition.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we found that claimant's work activities as a floor layer were a material contributing cause of increased symptoms in his underlying back condition. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that such a finding established the compensability of his occupational disease claim. Consequently, we reversed the Referee's order which had upheld the insurer's denial.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that his work activities were the major contributing cause of his condition or the worsening of his underlying condition. Aetna Casualty Co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of a claimant's condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (1992).

Here, Dr. Setera, claimant's treating chiropractor, was asked by claimant's attorney whether claimant's recent work activities had independently contributed to a worsening of claimant's underlying low back condition. In response, Dr. Setera reported that claimant's current symptomatology was related to his recent work activities. Specifically, Setera attributed 80 percent of claimant's current symptoms to his recent work activities and 20 percent to claimant's initial 1983 low back injury.

The Independent Chiropractic Consultants performed an independent medical examination. They concluded that claimant's work activities contributed to an exacerbation of his low back symptoms, but that there had been no worsening of his underlying low back condition.

The aforementioned medical evidence establishes that claimant's work activities contributed to an increase in the symptoms from his underlying low back condition. Nevertheless, neither opinion supports a conclusion that claimant's work activities resulted in a worsening of his underlying low back condition. Inasmuch as claimant must prove that his work activities were the major contributing cause of his low back condition or its worsening, we agree with the Referee's conclusion that the insurer's denial must be upheld.

Accordingly, on reconsideration, the Referee's order dated June 26, 1991 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAMI M. SHUREH, Claimant
WCB Case No. 90-06430
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Seifert's order which: (1) found that claimant suffered permanent impairment due to tinnitus, vestibular disequilibrium, trigeminal nerve disorder, and hearing loss; (2) increased claimant's unscheduled permanent disability award from 39 percent (124.8 degrees), as awarded by a Determination Order, to 56 percent (179.2 degrees); (3) awarded 20 percent scheduled permanent disability for a bilateral hearing loss, whereas the Determination Order had not granted such an award; and (4) directed the insurer to pay claimant's scheduled permanent disability award at a rate of $305 per degree. In his respondent's brief, claimant contends that his unscheduled permanent disability award should be increased to 64 percent (204.8 degrees). On review, the issues are permanent disability (scheduled and unscheduled) and the rate of scheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following additional finding.

Claimant stipulated at hearing that he was not contesting the accuracy of the figures on the evaluator's worksheet and that he was not contesting the Determination Order award. (Tr. 7). Instead, he was seeking permanent disability awards for tinnitus, vestibular equilibrium, a temporomandibular joint (TMJ) condition (trigeminal nerve disorder), and hearing loss.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had proven entitlement to unscheduled permanent disability awards for tinnitus, vestibular dysfunction and trigeminal nerve dysfunction. In addition, the Referee concluded claimant was entitled to a scheduled award for hearing loss. We agree with all the Referee's conclusions, but we modify the Referee's award for trigeminal nerve dysfunction.

Unscheduled Permanent Disability

Because claimant's condition became medically stationary on December 12, 1989, and his claim was closed by Determination Order on March 6, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. OAR 438-10-010(1).

The Determination Order, which awarded claimant 39 percent unscheduled permanent partial disability for his back and neck, is not in dispute. Claimant contends that in addition to the Determination Order award he is entitled to unscheduled awards for tinnitus, a vestibular disorder and a TMJ condition. The insurer contends that claimant has not proven permanent partial impairment from tinnitus, vestibular dysfunction or trigeminal nerve dysfunction (TMJ condition).

OAR 436-35-390(7)(b) provides for an award of 5 percent for tinnitus which interferes with a worker's ability to perform work. The insurer argues that an award for tinnitus is not appropriate because there is no evidence that claimant's tinnitus affects his ability to work. We disagree.

Dr. Mirka's June 25, 1990 report notes that claimant "is markedly impaired in performance" and continues to suffer from tinnitus bilaterally "as if it is in the middle of his head." (Ex. 82-2). Claimant's testimony also indicated the tinnitus interferes with his ability in class. The evidence supports the Referee's award of 5 percent for claimant's tinnitus condition.

The Referee awarded claimant 10 percent unscheduled permanent partial disability for vestibular disequilibrium. We agree.

Former OAR 436-35-390(7)(a)(A) provides for an award of 5-10 percent when signs of vestibular disequilibrium are present with supporting objective findings and the usual activities of daily living are performed without assistance, except for complex activities such as bike riding or walking on girders or scaffolds. Dr. Mirka reports: "Balance is poor, and he notes difficulty when running or in the shower. Stairs are also difficult. When walking routinely or doing daily activities, balance is relatively stable and tolerable." Based on this evidence, we conclude that claimant is entitled to an award of 10 percent for vestibular disequilibrium.

Former OAR 436-35-390(4)(b) provides for a maximum rating of 5 percent for complete loss of motor function of one trigeminal nerve. The Referee found claimant's impairment from this condition to be minimal, but awarded 5 percent. The insurer argues that there is no evidence that claimant suffers from loss of sensation in the trigeminal distribution or a complete loss of motor function of the nerve. We agree that the record does not support a loss of sensation. However, the evidence supports a loss of motor function, albeit minimal.

Dr. Williamson found crepitus in both temporomandibular joints, restricted maximum jaw opening, pain on palpation of the massater, temporalis, and internal and external pterygoid muscle groups. Dr. Williamson recommended an orthotic device to position the lower jaw in a physiologic position in relation to the upper jaw. The Referee found that, although claimant testified the plastic bite plate which he wears affects his speech, this was not apparent in his testimony at hearing.

Former OAR 436-35-320(3) provides that the maximum impairment value is given for a complete loss of use or function, but that a percentage of that figure shall be given for less than complete loss. Despite finding claimant's loss of motor function to be minimal, the Referee awarded claimant the maximum award allowable (5 percent). We modify the Referee's award. In lieu of the Referee's award, we hold that claimant is entitled to a proportional award of 1 percent for his minimal loss of motor function of the trigeminal nerve.

At hearing, claimant stipulated that the figures on the evaluator's worksheet were accurate and that claimant was not contesting the Determination Order which awarded 39 percent for his neck and back injury. Instead, claimant asserted that he should receive awards for hearing loss, tinnitus, TMJ and a vestibular condition in addition to the Determination Order awards for his back and neck. (Tr. 6-7). On review, claimant now contends that the adaptability factor used in the Determination Order was wrong and that he is also entitled to an award for a chronic condition limiting repetitive use of his neck and spine.

When an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Mavis v. SAIF, 45 Or App 1059 (1980); Richard C. Centeno, 41 Van Natta 617 (1989); Randy D. Johnson, 39 Van Natta 463 (1987). We have reasoned that to address an issue that was not raised at hearing would be fundamentally unfair. Gunther H. Jacobi, 41 Van Natta 1031 (1989). We decline to consider these issues on review.

We combine claimant's unscheduled impairment: claimant has 11 percent impairment of the low back, 10 percent impairment from a vestibular condition, 7 percent impairment of the neck, 5 percent impairment from tinnitus and 1 percent impairment from trigeminal nerve dysfunction. When combined these figures equal 31 percent impairment. We, therefore, modify the Referee's impairment finding to reflect claimant's 31 percent impairment.

When claimant's age value 0 is added to his education value 3, the sum is 3. When that value is multiplied by claimant's adaptability value 6, the product is 18. When that value is added to claimant's impairment value 31, the result is 49 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 49 percent.

Scheduled Disability

The insurer argues that none of claimant's audiograms were reliable. We are not persuaded that the April 20, 1990 audiogram relied on by the Referee in calculating claimant's hearing loss was unreliable. Claimant's responses on this audiogram were noted to be very consistent and reliable. This audiogram supports the 20 percent hearing loss award found by the Referee. Accordingly, we adopt the Referee's conclusions and reasoning on the issue of claimant's scheduled permanent disability due to hearing loss.

Rate of Payment of Scheduled Disability

We adopt the Referee's conclusions and reasoning concerning the issue of the proper rate of payment of claimant's scheduled disability award as set forth in his order. See Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991).

Claimant is entitled to an assessed attorney fee for services on review concerning the extent of scheduled permanent disability and rate of scheduled permanent disability issues. 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 attorney's services on review concerning the extent of scheduled disability and rate of scheduled disability issues is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 1, 1991 is affirmed in part and modified in part. In lieu of the Referee's award and in addition to the Determination Order award of 39 percent (124.8 degrees), claimant is awarded 10 percent (32 degrees) unscheduled permanent partial disability, giving claimant a total unscheduled permanent disability award to date of 49 percent (156.8 degrees). The remainder of the Referee's order is affirmed. For services on review concerning the extent of scheduled disability and rate of scheduled disability issues, claimant's counsel is awarded an assessed attorney fee of $1,000 to be paid by the insurer.

In the Matter of the Compensation of
VERITA A. WARE, Claimant
WCB Case Nos. 90-21831 & 91-05427
ORDER ON REVIEW
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Poland's order that dismissed her hearing requests concerning "de facto" denials regarding Precision Castparts and Cigna Insurance. Precision Castparts has moved the Board for an order dismissing claimant's request for review. Specifically, Precision Castparts contends that claimant has failed to file a timely brief and that claimant is appealing a Referee's order that dismissed claimant's hearing request that was withdrawn by claimant's attorney. Cigna has also moved for dismissal, asserting that it did not receive a copy of claimant's request for Board review. We deny the motions to dismiss and affirm the Referee's dismissal order.

FINDINGS OF FACT

In May 1991, claimant, through her then attorney-of-record, requested hearings concerning "de facto" denials regarding Precision Castparts and Cigna Insurance. Claimant raised issues such as compensability, temporary disability (partial and total), medical services, and penalties and attorney fees.

On November 21, 1991, claimant's attorney of record notified the Hearings Division that claimant was withdrawing her requests for hearing. On November 27, 1991, the Referee dismissed claimant's hearing requests.

On December 16, 1991, the Board received claimant's request for Board review. On December 17, 1991, the Board mailed an acknowledgment of claimant's request to all parties to the proceeding.

Copies of the hearing transcript were distributed to the parties on January 8, 1992. At that time, a briefing schedule was implemented.

Claimant's appellant's brief was due January 29, 1992. Prior to that date, claimant neither submitted an appellant's brief nor sought an extension of time to file a brief.

On February 5, 1992, Precision Castparts moved for dismissal of claimant's request for Board review. Precision noted that claimant's attorney had withdrawn claimant's hearing requests, there was no record for review, and claimant had not filed an appellant's brief.

On February 11, 1992, the Board's counsel granted Cigna and claimant an opportunity to respond to Precision's motion. In particular, claimant was requested to indicate whether she was contesting the fact that her attorney-of-record had withdrawn her hearing requests. The parties were requested to respond within 21 days.

On February 19, 1992, Cigna moved for dismissal of claimant's request for Board review. Asserting that it had never received a copy of claimant's request for review, Cigna argued that her appeal was defective.

No response from claimant has been received within the aforementioned 21-day period.

CONCLUSIONS OF LAW

To begin, we address Cigna's motion to dismiss. Cigna contends that the Board lacks jurisdiction to consider claimant's request because Cigna never received a copy of the request. We disagree.

Since the Board's December 17, 1991 acknowledgment letter was mailed to all parties 20 days after the Referee's November 27, 1991 dismissal order, we conclude that it is more probable than not that all parties to the hearing received actual notice of claimant's request for review within the statutory 30-day period. See Denise M. Bowman, 40 Van Natta 363 (1988). Under such circumstances, the Board has jurisdiction to consider claimant's request for review, notwithstanding her failure to provide a copy of her request to all parties. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983); Denise M. Bowman, supra.

We turn to Precision's motion to dismiss. Contending that no exhibits were admitted, no hearing was convened and that the hearing was dismissed pursuant to claimant's former attorney's request, Precision Castparts seeks dismissal of claimant's request for Board review. We deny the motion.

Notwithstanding the circumstances discussed in Precision's motion, the fact remains that, as a result of the Referee's order, claimant's requests for hearing concerning the issues of compensability, temporary disability, medical services, and penalties and attorney fees were dismissed. Consequently, at least as a procedural, if not a substantive matter, the order has the potential of impacting claimant's entitlement to compensation. In that respect, it is an appealable final order. See Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974); Donald L. Lowe, 41 Van Natta 1873 (1989).

Inasmuch as claimant timely requested Board review, the Referee's dismissal order has not become final. See ORS 656.289(3); 656.295(2). Furthermore, after conducting our review, we are authorized to affirm, reverse, modify, or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6). Thus, the issue of whether claimant withdrew her hearing request remains viable. Donald L. Lowe, supra. Accordingly, the motion to dismiss on such a ground is denied.

Finally, Precision Castparts seeks dismissal of claimant's request for review because she failed to timely submit an appellant's brief. Yet, the filing of briefs is not jurisdictional. OAR 438-11-020(1); Bonnie A. Heisler, 39 Van Natta 812 (1987). Accordingly, the motion to dismiss on that ground is likewise denied.

We proceed to a review of the merits of claimant's request for review. The record establishes that claimant's hearing requests were dismissed in response to claimant's then-attorney's withdrawal of those requests. There is no evidence to contradict this conclusion. Accordingly, we affirm the Referee's dismissal order.

ORDER

The Referee's order dated November 27, 1991 is affirmed.

In the Matter of the Compensation of
DENITA CLEVELAND (HALL), Claimant
WCB Case No. TP-91022
THIRD PARTY DISTRIBUTION ORDER
Daryl Nelson, Defense Attorney

Claimant has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. See ORS 656.587. We approve the settlement.

FINDINGS OF FACT

In May 1990 claimant sustained a compensable back injury as a result of a motor vehicle accident. Her vehicle was rear-ended. Dr. Gilberts, an emergency room physician, diagnosed cervical strain. X-rays were normal.

Since the accident, claimant has received conservative treatment for neck and low back pain. She has undergone physical therapy, but has not been administered anti-inflammatory medication because of a history of nephritis.

Initial attempts to return to light duty work were unsuccessful since claimant's complaints reappeared. In January 1991, she was enrolled in a work hardening program. She completed the program in March 1991.

A Determination Order issued on April 30, 1991. Claimant was awarded temporary disability, less time worked, from May 7, 1990 through March 5, 1991, when her condition was found to be medically stationary. Claimant was also granted 13 percent unscheduled permanent disability.

In June 1991 claimant returned to her regular work as a courier on a half-time basis. Shortly thereafter, she began working full-time and is currently performing such duties with minimal problems. She continues to periodically seek conservative treatment for her pain complaints.

An August 30, 1991 Order on Reconsideration from the Workers' Compensation Division affirmed the April 30, 1991 Determination Order in all respects. Thereafter, claimant requested a hearing concerning the Order on Reconsideration.

In December 1991, Dr. Bowles, claimant's current treating osteopath, reported that claimant was "still complaining of lower back pain." In light of such complaints, Bowles found "it hard to state that her problem is resolved." Although claimant's problem "certainly may be stable at his point, [Dr. Bowles] certainly [could not] say that it is resolved based on what she tells me." In offering these comments, Dr. Bowles noted that he had only recently begun treating claimant and that "it is hard to get a full grasp on her medical history after one visit."

In December 1991 and in January 1992, claimant advised the Hearings Division that she did not wish to pursue her request for hearing. Consequently, pursuant to a Referee's February 5, 1992 dismissal order, claimant's hearing request was dismissed.

Claimant was involved in a November 1983 motor vehicle accident in which she suffered a right wrist fracture. Since that accident she has occasionally suffered right wrist complaints, which have been attributed to tendonitis.

To date, Liberty Northwest, as paying agency, has incurred actual claim costs totalling $15,798.85. These costs include medical expenses and temporary disability compensation.

Claimant, pro se, has been in negotiations with the third party insurer concerning her potential cause of action for negligence against the driver of the other vehicle. The third party insurer and claimant have agreed to settle the action for $19,000. The third party's policy limits are $25,000.

Liberty Northwest declines to approve the settlement. Contending that Dr. Bowles does not consider claimant's condition to be "medically stationary," Liberty argues that it would be premature to evaluate claimant's claim. Furthermore, noting that its lien would not be fully reimbursed if the settlement proceeds totalled $19,000, Liberty Northwest asserts that claimant should continue her efforts to receive the $25,000 third party insurer's policy limits.

FINDING OF ULTIMATE FACT

The third party settlement offer of $19,000 is reasonable.

CONCLUSION OF LAW

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

A paying agency's failure to recover full reimbursement for its entire lien is not determinative as to whether a third party settlement is reasonable. See Jill R. Atchley, 43 Van Natta 1282, 1283 (1991); John C. Lappen, 43 Van Natta 63 (1991). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Jill R. Atchley, supra; Kathryn I. Looney, 39 Van Natta 1400 (1987).

In withholding its approval of the proposed settlement, Liberty Northwest asserts that it would be premature to evaluate claimant's claim because her condition is not medically stationary. Yet, Dr. Bowles, the physician whose opinion Liberty Northwest relies on for its contention, does not advance such a conclusion. To the contrary, Bowles declares that, although claimant's pain complaints remain unresolved, her problem "certainly may be stable at this point." Moreover, in light of his recent introduction to claimant's court of treatment, Dr. Bowles acknowledged his unfamiliarity with her medical history.

Such evidence does not lead us to the conclusion that it would be premature to evaluate claimant's claim, particularly when her claim has been closed since the April 1991 Determination Order and claimant's hearing request from the August 1991 Order on Reconsideration which had affirmed that Determination Order has been dismissed pursuant to a Referee's February 5, 1992 dismissal order. (In reaching this conclusion, we have taken administrative notice of the Order on Reconsideration and the Referee's dismissal order because the orders are capable of accurate and ready determination and their accuracy cannot reasonably be questioned. Grace B. Simpson, 43 Van Natta 1276, 1277 (1991)). Furthermore, since the Referee's dismissal order was not appealed within 30 days of its issuance, it has become final by operation of law. ORS 656.289(3). Therefore, the evaluations of claimant's compensable condition as rendered in the April 1991 Determination Order and affirmed in the August 1991 Order on Reconsideration have become final.

Finally, noting that it would not receive full reimbursement for its lien if a $19,000 settlement is approved, Liberty Northwest contends that claimant should persist until the third party insurer offers its full policy limits of $25,000. Although its $15,798.85 lien would not be fully satisfied by its two-

thirds share of a $19,000 settlement, Liberty Northwest would receive approximately 80 percent of its asserted lien ($12,666.67). In any event, a paying agency's inability to receive full satisfaction of its lien does not equate to a determination that a third party compromise is unreasonable. See Jill R. Atchley, supra; John C. Lappen, supra.

After reviewing the parties' respective positions and considering the aforementioned standard, we conclude that a settlement offer of $19,000 is reasonable. Consequently, we approve the settlement.

Accordingly, proceeds of the settlement shall be distributed in accordance with ORS 656.593(1). Specifically, claimant shall received one-third of the proceeds ($6,333.33). Since Liberty Northwest's uncontested lien exceeds the remaining balance of settlement proceeds, Liberty Northwest shall receive the remainder ($12,666.67).

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD HARRIS, Claimant
WCB Case No. 91-01509
ORDER ON REVIEW (REMANDING)
Daryl Nelson, Defense Attorney

Claimant, pro se, requests review of Referee Neal's order that dismissed his request for hearing because claimant failed to appear at hearing. On review, the issue is the propriety of the dismissal. We remand.

FINDINGS OF FACT

Claimant requested a hearing on February 5, 1991 from the insurer's December 7, 1990 denial. A hearing was set for April 26, 1991.

Claimant, who was unrepresented, failed to appear at hearing. The Referee granted the insurer's motion to dismiss the hearing request. The Referee's dismissal order was entered on April 30, 1991.

On May 30, 1991, the Board received claimant's May 28, 1991 response to the Referee's order. Claimant stated that he was dissatisfied with the Referee's order and requested that the Order of Dismissal "be reviewed and a new date set for claimant." In his letter, claimant stated that he had not received any notice that the hearing had been set for April 26, 1991.

CONCLUSIONS OF LAW AND OPINION

A Referee shall dismiss a request for hearing if claimant and his attorney fail to attend a scheduled hearing unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 438-06-071(2). A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." OAR 438-06-081. We have previously held that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989). In Luthy, we treated a post-hearing request to reschedule a hearing as a motion for postponement.

Here, in response to the Referee's April 30, 1991 dismissal order, claimant submitted a May 28, 1991 letter expressing dissatisfaction with the decision. Specifically, claimant contended that he had never received notice that the hearing had been set.

Considering these circumstances, we interpret claimant's letter as a motion for postponement of the scheduled hearing. Inasmuch as the Referee did not have an opportunity to rule on the motion, this matter must be remanded to the Referee for consideration of the motion. See Ray Eaglin, 43 Van Natta 1175 (1991).

In reaching this conclusion, we recognize the insurer's objections to the representation made in claimant's letter and its contention that there was no indication that the notice of hearing had ever been returned. Our decision should not be interpreted as a ruling either upon the credibility of the representation made by claimant or a finding on whether postponement is warranted. Rather, we find that the Referee is the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Eaglin, supra.

Accordingly, the Referee's order dated April 30, 1991 is vacated. This matter is remanded to Referee Neal to determine whether postponement of claimant's hearing request is justified. In making this determination, the Referee shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the Referee finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the Referee. If the Referee finds that a postponement is not justified, the Referee shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

March 17, 1992 Cite as 44 Van Natta 469 (1992)

In the Matter of the Compensation of
DAVE E. HERMAN, Claimant
WCB Case No. 88-22454
ORDER ON REVIEW
Aspell, et al., Claimant Attorneys
Vavrosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Mongrain's order that awarded claimant's counsel an assessed attorney fee for the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and Supplemental Findings of Fact. We do not adopt the Referee's Ultimate Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The insurer contends that the Referee should not have assessed an attorney fee under ORS 656.382(1), as there is no evidence that the reasonableness of the insurer's conduct was in issue at hearing. We agree.

ORS 656.382(1) authorizes the assessment of an attorney fee if a carrier refuses to pay compensation due under a referee, Board or court order or otherwise "unreasonably resists the payment of compensation." Where an insurer engages in conduct which constitutes unreasonable resistance to the payment of compensation, but does not violate ORS 656.262(10) or there are no amounts then due upon which to assess a penalty so that claimant's attorney would not be entitled to one-half of an additional amount under ORS 656.262(10), a claimant's attorney is entitled to an attorney fee under ORS 656.382(1) for such unreasonable resistance. See Nicolasa Martinez, 43 Van Natta 1638 (1991).

In the present case, however, we find no evidence that claimant asserted entitlement to a penalty and related fee or to a separate attorney fee under ORS 656.382(1). Rather, the matter was remanded to the Referee to determine whether claimant sustained an aggravation subsequent to his last award of compensation. At hearing, the Referee stated that, in accord with the directions provided within the Board's order on remand, he would consider additional medical evidence and decide whether claimant sustained an aggravation following his last award of compensation. (Tr. 2). Additionally, the parties agreed with the Referee that the issue on remand was aggravation. (Tr. 3, 4).

There is no evidence that the parties litigated the issue of the reasonableness of the employer's conduct. Specifically, there is no evidence that the parties litigated a penalty and related fee or entitlement to an attorney fee under ORS 656.382(1). Under the circumstances, we agree with the insurer that the issue was not before the Referee. See Mavis v. SAIF, 45 Or App 1059 (1980).

Although claimant is not entitled to an attorney fee on the basis of ORS 656.382(1), we nonetheless find that he is entitled to an attorney fee pursuant to ORS 656.386(1). We do not agree with the insurer's contention that the only issue on review is whether the Referee correctly awarded a separate attorney fee on the basis of an unreasonable resistance to the payment of compensation. The scope of our de novo review encompasses all issues considered by the Referee. Our review is not limited to those issues specifically raised by the parties on review. Destael v. Nicolai Co., 80 Or App 596 (1986); Donald A. Williams, 43 Van Natta 1892 (1991). Pursuant to ORS 656.295(6), we may affirm, reverse, modify or supplement the order of the referee and make such disposition of the case as we determine to be appropriate. Accordingly, because the issue of entitlement to an attorney fee pursuant to ORS 656.386(1) was an issue before the Referee, we now address that issue on review.

The Referee relied upon Duane L. Jones, 42 Van Natta 875 (1990), and concluded that no attorney fee was available for a denial rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1)(amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, 3. Such is the case here.

The insurer concedes that claimant's counsel was instrumental in obtaining compensation for claimant associated with the insurer's acceptance of the surgery. (Appellant's Brief pg. 6). We agree. Accordingly, we conclude that an attorney fee is warranted.

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 prior to hearing concerning the surgery denial is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case and the value of the interest involved.

ORDER

The Referee's order dated March 12, 1991, as amended by the June 14, 1991 order, is modified in part. That portion of the Referee's order that awarded claimant an assessed attorney fee of $2,500 pursuant to ORS 656.382(1) is modified. In lieu of the Referee's award, claimant's counsel is awarded an assessed attorney fee of $2,500, payable by the insurer, pursuant to ORS 656.386(1) for services rendered prior to hearing on the surgery issue. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
SOPHIA LOREDO, Claimant
WCB Case No. 91-02192
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Otto's order that: (1) upheld the insurer's denial of her bilateral wrist and elbow tendinitis and lateral epicondylitis conditions of both elbows; and (2) upheld the insurer's denial of her shoulder, neck and mid-back conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's Conclusions of Law, with the following supplementation.

On review, claimant contends that she has established compensability of her bilateral wrist and elbow conditions, regardless of the fact that she gave the doctors an incomplete history of her prior back and shoulder problems. Claimant argues that, because she has never sought treatment for her wrist and elbow conditions prior to her work for the employer, it is not relevant that she failed to provide the doctors with a correct history of her previous back and shoulder conditions and treatments. We disagree.

The Referee found that claimant received treatment for her back, shoulder and neck symptoms for approximately ten years prior to her work with the employer. When examined for her elbow and wrist pain (in addition to her neck and shoulder pain), claimant denied any injuries (other than the motor vehicle accident) to her "neck, back or extremities." Ex. 13-2. She also reported that she had not had any "muscle, joint or bone problems in her lifetime." Id.

Under the circumstances, we decline to speculate, as claimant has requested, that information regarding her prior neck, shoulder and back symptoms and treatment were unnecessary to the accurate diagnosis of her elbow and wrist conditions. Accordingly, we agree with the Referee that, because all of the medical evidence in the case was based upon an inaccurate and incomplete history of claimant's prior conditions, she has failed to establish that her work activities were the major cause of her bilateral wrist and elbow conditions or her shoulder, neck and mid-back conditions. We, therefore, affirm the Referee on the issue of compensability.

ORDER

The Referee's order dated June 12, 1991 is affirmed.

March 17, 1992 Cite as 44 Van Natta 472 (1992)

In the Matter of the Compensation of
MARTHA B. JOHNSON, Claimant
WCB Case No. 90-19241
ORDER ON REVIEW
Depaolis, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Black's order that declined to award unscheduled permanent disability for her brachial plexus condition. In its brief, the insurer requests review of that portion of the Referee's order that assessed a penalty and a related fee pursuant to ORS 656.262(10)(a) for an allegedly unreasonable resistance to the payment of compensation. On review, the issues are extent of unscheduled permanent disability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled permanent disability

On review, claimant contends that the Referee erred by not awarding her unscheduled permanent disability for loss of repetitive use of her shoulder. Claimant also contends that she is entitled to unscheduled permanent disability for loss of strength due to her brachial plexus injury. Claimant asserts that the reports of Dr. Karasek imply that her shoulder pain is related to the surgery performed for the compensable condition.

The insurer argues that claimant has not established that her shoulder problems are related to her accepted hand and wrist conditions. In September 1988, Dr. Karasek reported that claimant had an operation for her work injury to the left wrist and had experienced complications. He opined that claimant had "probably" suffered a brachial plexus injury on the left. In May 1989, Dr. Karasek responded to the insurer's request for a report on claimant's impairment. His report described claimant's impairment as existing in her hand, wrist and forearm.

In July 1989, Dr. Karasek noted that claimant had a 25 percent reduction in brachial radialis and deltoid strength in the left arm, in addition to reduced left arm endurance. He diagnosed chronic arm pain secondary to brachial plexus injury, cutaneous nerve of the forearm injury, and chronic carpal tunnel. He further reported that all of the findings were "complicated by emotional dismay over legal issues about this injury."

On September 29, 1989, Dr. Butters examined claimant's left shoulder upon request from Dr. Karasek. He opined that claimant's left shoulder problem was an impingement syndrome with rotator cuff tendinitis, unrelated to her

neurological problem. In January 1990, Dr. Karasek agreed with Dr. Butters' range of motion findings for claimant's left shoulder.

In January 1991, Dr. Karasek checked his agreement to a form letter stating that claimant's loss of deltoid range of motion was due to a brachial plexus injury.

We agree with the Referee's conclusion that claimant has not established entitlement to unscheduled permanent disability. Claimant is attempting to assert entitlement to an award of unscheduled permanent disability resulting from a consequential condition. See Julie K. Gasperino, 43 Van Natta 1151 (1991). However, in this case, claimant is contending that her upper back and shoulder problems arose as a result of the surgery, not as a result of an injury to the back and shoulder incurred at the same time as the initial compensable injury. Accordingly, claimant's condition is properly characterized as a "secondarily consequential condition" and she must prove that the original injury was the major contributing cause of her consequential back and shoulder problems. ORS 656.005(7)(a)(A); Gasperino, supra.

Here, Dr. Karasek reported that, as a result of the compensable surgery, claimant had "probably" suffered a brachial plexus injury. However, Dr. Karasek later reported that such findings were caused by emotional dismay over legal issues. See e.g. Norma J. Overman, 43 Van Natta 2816 (1991)(Claimant failed to establish permanent impairment due to the compensable injury where the evidence showed a psychological contribution to impairment). Furthermore, Dr. Butters, to whom Dr. Karasek referred claimant, has reported that claimant's shoulder problem was unrelated to her injury. Dr. Karasek has never specifically rebutted that report.

Under the circumstances, we conclude that claimant has failed to prove that her compensable hand/wrist injury is the major contributing cause of her upper back and shoulder condition. Additionally, claimant has not proven that impairment of her shoulder or back is due to her compensable injury. ORS 656.214; former OAR 436-35-010 and 436-35-270. Accordingly, we affirm the Referee on the issue of unscheduled permanent disability.

Penalties and attorney fees

The insurer contends that a penalty should not have been assessed in this case as there is no evidence that the untimely disclosure of Dr. Karasek's report resulted in any delay of compensation. We disagree. In the present case, the Referee found that, because of the insurer's delay, he was required to leave the record open. Further documents were submitted and oral closing arguments were not heard until approximately four months after the hearing. The Referee's order subsequently resulted in increased compensation to claimant. Under such circumstances, we find that the delay in producing the document resulted in unreasonable delay of compensation. Accordingly, we affirm the Referee on the penalty issue. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991).

Inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending the Referee's order concerning these issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 30, 1991 is affirmed.

In the Matter of the Compensation of
BEVERLY Y. MOORE, Claimant
WCB Case No. 90-21625
ORDER ON REVIEW (REMANDING)
Roger D. Wallingford, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Menashe's order that upheld the insurer's denial of claimant's occupational disease claim for a right knee condition. On review, claimant contends that her claim is compensable. Alternatively, she seeks remand for the submission of additional medical evidence (medical reports from Dr. Johnson, the surgeon who performed two of claimant's prior knee surgeries). On review, the issues are remand and compensability. We remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

After the insurer denied claimant's occupational disease claim, claimant retained an attorney on November 26, 1990. (Tr. 2). By letters dated December 2, 1990 and January 2, 1991, claimant's attorney contacted the insurer and requested a copy of the claim file.

Claimant's attorney did not receive the file until the hearing exhibits arrived on January 24, 1991. (Tr. 2). Prior to receiving the exhibits, claimant's attorney was not aware that Dr. Johnson had performed claimant's 1988 knee replacement and her December 1990 wire removal surgeries. (Tr. 5).

Claimant's attorney tried to contact Dr. Johnson by telephone several times but was unsuccessful because Johnson was unavailable due to a disabling back condition. (Tr. 6). Claimant's attorney did not attempt to contact Johnson by letter because he was unsure whether Johnson was still receiving mail at the clinic where Johnson worked. (Tr. 7).

The hearing took place on February 19, 1991. As of the date of the hearing, claimant's attorney was still trying to schedule an appointment with Johnson through Johnson's nurse. (Tr. 7).

ULTIMATE FINDINGS OF FACT

The record is incompletely developed. Material evidence in the form of a medical report or testimony from Dr. Johnson, claimant's treating surgeon, was not obtainable with the exercise of due diligence at the time of the February 19, 1991 hearing.

CONCLUSIONS OF LAW AND OPINION

At the beginning of the hearing, claimant requested that the record be left open in order to submit Dr. Johnson's medical report concerning claimant's occupational disease claim. (Tr. 2). The Referee denied claimant's motion because he concluded that claimant failed to establish due diligence in obtaining Dr. Johnson's report. (Tr. 7). On review, claimant asserts that the Referee erred in denying her motion to continue the hearing for the admission of Dr. Johnson's report and alternatively seeks remand for consideration of that report. We agree that remand for the consideration of this evidence is warranted.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must

clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Here, claimant did not retain her attorney until November 26, 1990, less than three months before her hearing on February 19, 1991. Once retained, claimant's attorney twice requested a copy of claimant's file from the insurer but received nothing until the exhibits arrived three weeks before the hearing. When the exhibits arrived, claimant's attorney realized for the first time that Dr. Johnson was involved in claimant's case. Thereafter, claimant's attorney tried repeatedly to contact Johnson only to find that, because of a disabling back condition, Johnson was no longer practicing and was no longer at his former clinic. As of the date of the hearing, claimant's attorney was still trying to schedule an appointment with Dr. Johnson.

We find that these facts establish that claimant's attorney exercised due diligence in trying to obtain Dr. Johnson's opinion concerning claimant's knee condition prior to hearing. In light of these circumstances, we are persuaded that Dr. Johnson's report was not obtainable with due diligence at the time of the hearing and conclude that, without this report, the record is incompletely developed. Consequently, we grant the motion to remand.

Accordingly, this matter is remanded to Referee Menashe with instructions to reopen the record for the submission of medical evidence from Dr. Johnson. This submission of evidence may be presented in any manner in which the Referee finds achieves substantial justice to all parties and insures a complete and accurate record of all examination and/or testimony (including cross-examination).

ORDER

The Referee's order dated February 26, 1991 is vacated. This matter is remanded to Referee Menashe for further proceedings consistent with this order.

March 17, 1992 Cite as 44 Van Natta 475 (1992)

In the Matter of the Compensation of
PATRICK E. RILEY, Claimant
WCB Case No. 90-15318
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

The self-insured employer requests reconsideration of our February 18, 1992 Order on Review. In that order, we held that: (1) the Hearings Division had jurisdiction to enforce a stipulated settlement that made no reference to any statute or administrative rule; and (2) medical services provided by a psychologist were compensable because the clear language of the stipulation did not limit claimant's treatment to that provided exclusively by a psychiatrist. On reconsideration, the employer contends that: (1) Exhibit 35A indicated that the purpose of the stipulation was to limit claimant's treatment to that provided by a psychiatrist; and (2) the clear language of the stipulation limited claimant's treatment to that provided solely by a psychiatrist.

With regard to the first contention we offer the following comment. The two letters between counsel, Exhibit 35A and 35b, do not in our view, prove that a dispute concerning the reasonableness and necessity of treatment with a psychologist was the genesis of the stipulation, or that such a dispute even existed prior to the stipulation's preparation. Therefore, we adhere to our decision on this point.

With regard to the employer's second contention, we conclude that our order adequately addresses this issue and we decline to discuss the issue further.

Accordingly, our February 28, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

March 17, 1992 Cite as 44 Van Natta 476 (1992)

In the Matter of the Compensation of
GERALD D. SPENCER, Claimant
Own Motion No. 66-0226M
OWN MOTION ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our February 19, 1992 Own Motion Order on Reconsideration in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order.

IT IS SO ORDERED.

March 17, 1992 Cite as 44 Van Natta 476 (1992)

In the Matter of the Compensation of
JULIE A. WILKER, Claimant
WCB Case No. 90-15644
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Gruber's order that: (1) upheld the SAIF Corporation's partial denial of claimant's costachondral discomfort, situational anxiety, and esophagitis conditions; (2) upheld SAIF's denial of claimant's reimbursement claim for travel expenses; and (3) declined to assess penalties and attorney fees for an allegedly unreasonable failure to authorize a specified treatment. On review, the issues are compensability, travel expenses, and penalties and attorney fees.

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

Claimant contends that SAIF unreasonably failed to timely authorize Dr. Yanney's proposed dental treatment plan. Specifically, she asserts that SAIF was required to respond within 72 hours because Yanney's plan involved elective surgery. Assuming without deciding that OAR 436-10-070 was applicable, we do not consider SAIF's conduct to have been unreasonable.

The record establishes that SAIF did not receive Dr. Yanney's request for authorization until August 27, 1990. As documented by SAIF's claim examiner's

September 27, 1990 letter, x-rays and arthrograms were not provided with Dr. Yanney's request and such materials were necessary before SAIF's dental consultant could evaluate the dental treatment plan. Consequently, claimant's attorney was notified that the aforementioned information was being accumulated to permit SAIF to perform its investigation of the proposed treatment authorization request. Upon receipt of the requested materials and the consultant's appraisal of the proposed treatment plan, SAIF provided its written authorization on October 19, 1990. Under such circumstances, we do not find SAIF's conduct to be unreasonable. Accordingly, penalties and attorney fees are not warranted.

ORDER

The Referee's order dated February 1, 1991 is affirmed.

March 18, 1992 Cite as 44 Van Natta 477 (1992)

In the Matter of the Compensation of
BARBARA HOLLAND, Claimant
WCB Case No. 91-01025
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's partial denial of claimant's left shoulder, left elbow, right cervical-dorsal strain, and lumbar disc disease conditions; and (2) declined to assess penalties and a penalty-related attorney fee for SAIF's allegedly unreasonable partial denial. On review, the issues are compensability of claimant's consequential conditions, penalties, and attorney fees.

We affirm and adopt the Referee's order with the following comment. Under ORS 656.005(7)(a)(A), a worker who suffers a second injury as a consequence of the original compensable injury will be compensated for the second condition only if the compensable injury is the major contributing cause of that injury. See Julie K. Gasperino, 43 Van Natta 1151 (1991). Claimant has not sustained her burden of proof under ORS 656.005(7)(a)(A).

ORDER

The Referee's order dated May 15, 1991 is affirmed.

March 19, 1992 Cite as 44 Van Natta 477 (1992)

In the Matter of the Compensation of
DUNG T. NGUYEN, Claimant
WCB Case No. 89-05167
ORDER ON RECONSIDERATION
Becker, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Claimant requests reconsideration of our February 28, 1992 order on remand which affirmed the Referee's order finding that claimant failed to prove a compensable occupational disease under former ORS 656.802(1)(c). The self-insured employer's response has been received.

Claimant first points out that, in our prior October 2, 1990 order on review, we found the opinions of Dr. Howell, D.O., and the treating physician, Dr.

Holm, D.C., to be persuasive and well-reasoned but rejected the opinion of the Western Medical Consultants. Claimant then calls our attention to language in our order on remand giving greater weight to the opinion of the Western Medical Consultants but rejecting the opinions of Howell and Holm.

We agree that our order on remand reaches different conclusions than the order on review in regard to the weight and reliance placed on the medical experts. The order on review rejected the opinion of the Western Medical Consultants on the basis that it did not address causation. The order on review also found the reports of Holm and Howell to be persuasive and well-reasoned. Upon further consideration of the medical evidence on remand, however, we found that the opinions of Howell and Holm were not based on complete information because their reports failed to indicate that they were aware of x-rays showing compression of claimant's vertebra. Furthermore, we found that the opinion of the Consultants addressed causation and was the more persuasive opinion because it analyzed the effect of the compression in the vertebra.

Claimant next disagrees with our finding on remand that the opinion of the Western Medical Consultants was well-reasoned and persuasive, contending that the Consultants failed to indicate any knowledge of claimant's work conditions. We disagree. The report of the Consultants stated that it had reviewed various reports, including that of Dr. Howell, which contained very detailed descriptions of claimant's work duties. We therefore adhere to our finding that the Consultants provided the more persuasive opinion.

Accordingly, our February 28, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 28, 1992 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
GERARDO C. AGUILAR, Claimant
WCB Case No. 91-01641
ORDER ON REVIEW
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant, pro se, requests review of Referee Brown's order which held that the parties had stipulated that: (1) the insurer would pay Dr. Herbert's bill on a diagnostic basis; (2) the insurer's February 6, 1991 denial is upheld; and (3) the issue of temporary total disability entitlement is deferred for determination by the Director on reconsideration. On review, the issue is the validity of the stipulated agreement. We affirm.

FINDINGS OF FACT

On February 6, 1991, claimant, through his then-attorney of record, requested a hearing raising the issues of temporary total disability, penalties, and attorney fees. That hearing request was acknowledged as WCB 91-01641. That same day, the insurer issued a partial denial of claimant's hiatus hernia and esophageal reflux as unrelated to an August 1989 middle and low back injury claim.

On February 20, 1991, a Determination Order issued, reclosing claimant's 1989 claim. (A December 1989 Determination Order had been set aside by a June 1990 Referee's order.) On March 26, 1991, claimant filed a supplemental hearing request, raising the issue of the insurer's February 6, 1991 denial.

The case proceeded to hearing on May 2, 1991. Claimant did not attend the hearing, but was represented by his former attorney. At that time, the Referee orally noted that the parties had settled the dispute. The Referee stated that the parties agreed that: (1) the insurer would pay for a diagnostic bill; (2) the insurer's February 6, 1991 denial would be upheld; and (3) the issue of temporary total disability would be deferred for a determination by the Director on reconsideration. This agreement was incorporated into the Referee's May 2, 1991 order.

CONCLUSIONS OF LAW AND OPINION

The issue at hand is whether claimant is bound by the terms of the stipulated agreement entered into at hearing.

Claimant requests that the order be set aside due to his dissatisfaction with his former counsel's efforts. Claimant has cited no authority which supports the contention that this is an appropriate ground for setting aside the Order on a Stipulation. Nor are we aware of any authority to support such a position. Moreover, we note that claimant retained counsel to represent him without his presence at hearing. Through claimant's counsel's representation, the Referee approved the parties' stipulated agreement. Claimant does not contend that the agreement was entered into without his understanding and consent. Therefore, we conclude that claimant has not established circumstances necessary to set aside the agreement. Accordingly, we decline to set the order aside. Claimant's remedy, if any exists, for his dissatisfaction with his counsel's representation, lies outside the workers' compensation system.

ORDER

The Referee's order dated May 2, 1991 is affirmed.

March 20, 1992 Cite as 44 Van Natta 479 (1992)

In the Matter of the Compensation of
WARREN H. CHARLESTON, Claimant
WCB Case No. 90-19644
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee Neal's order that: (1) upheld the insurer's partial denial of claimant's left foot conditions diagnosed as pes planovalgus and subtalar arthritis; (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial; (3) declined to assess penalties and attorney fees for an allegedly unreasonable back-up denial; and (4) declined to assess penalties and attorney fees for a late denial. On review, the issues are compensability and penalties and attorney fees.

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

Claimant argues that the insurer is estopped from denying the requested surgery based on a June 1990 letter from the employer. We disagree.

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. 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. See also Bennet v. City of Salem, 192 Or 531, 541 (1951).

In a letter dated June 12, 1990, the employer wrote claimant to "reassure you that Workmen's Comp. will have to pay for the surgery you require." (Ex. 9A). However, we find that the employer was without knowledge of the facts, that is, whether the condition requiring surgery was compensable. Because all elements of estoppel must be met, and we find that the employer's statement was made without knowledge of the facts, we do not address the remaining elements for establishing equitable estoppel. Accordingly, for these reasons, in addition to those addressed by the Referee, we find that the insurer was not estopped from denying the requested surgery by the employer's statement.

ORDER

The Referee's order dated May 13, 1991 is affirmed.

March 20, 1992 Cite as 44 Van Natta 480 (1992)

In the Matter of the Compensation of
JAMES J. ELLENWOOD, Claimant
Own Motion No. 91-0642M
INTERIM OWN MOTION ORDER
Keeton & Tait, Claimant Attorneys

The self-insured employer submitted claimant's claim for an alleged worsening of his September 18, 1975 compensable injury. The employer recommends that the above-captioned claim not be reopened on the ground that surgery for claimant's current condition is not reasonable and necessary and that claimant has withdrawn from the work force.

The employer has failed to provide supporting evidence for its contentions, including: (1) a copy of the insurer's (or claimant's) request for Director's review of the reasonableness and necessity of the proposed surgery pursuant to ORS 656.327 and OAR 436-10-046; (2) a copy of the insurer's formal denial of current medical services pursuant to ORS 656.262; and (3) evidence that claimant was informed that he must prove that he is willing to work and that either: (a) he is making reasonable efforts to obtain work; or (b) reasonable efforts to obtain work would be futile due to the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

In addition, we lack the following evidence: (1) the date claimant's aggravation rights expired; (2) the original body parts injured; (3) the original conditions accepted; (4) the current condition and body part that is the subject of this claim; (5) whether hospitalization or surgery has been requested; and (6) medical evidence establishing that the current condition is compensably related to claimant's original injury.

Accordingly, we require the parties to provide such evidence within 14 days of the date of this interim order. At that time, we will take this case under advisement.

In the Matter of the Compensation of
ALICE C. LANE, Claimant
WCB Case No. 90-06517
ORDER ON REVIEW
W.D. Bates, Jr., Claimant Attorney
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Black's order which: (1) found that claimant's psychological condition was not causally related to her compensable low back condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for a psychological condition. On review, the issues are compensability and aggravation. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the following:

> "In April of 1990, claimant scored 24 on the Beck depression inventory. Approximate ranges for major depression on an episodic basis is a score of 40; 39 would be an appropriate score for recurrent major depression." (Opinion & Order at 2).

Instead, we find that claimant's raw score of 24 is equivalent to a linear T score of 40 for Major Depression (single episode) and 39 for Major Depression (recurrent episode), and that the score suggests that claimant was experiencing moderate to severe depression at that time (in April 1990). (Ex. 71cc(b)-2).

We adopt the Referee's first finding of ultimate fact, but not the second. Instead, we find that claimant's compensable low back condition and its sequelae were the major contributing cause of her current need for psychiatric treatment.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that her psychological condition is compensable, and that she has an aggravation claim based on this psychological condition. The Referee found that claimant's psychological condition is not compensable because claimant failed to establish that her 1984 low back injury was the major contributing cause of the current psychological condition and need for treatment. We disagree.

Compensability

Whether we view the psychological condition as a secondary consequence of claimant's 1984 back injury, or as resulting from the combination of her 1984 injury with a preexisting condition, claimant must establish that her compensable injury and its sequelae were the major contributing cause of her current psychological condition. ORS 656.005(7)(a)(A) and (B); see also, Julie K. Gasperino, 43 Van Natta 1151 (1991). We find that the causation issue is a complex medical question, resolution of which turns largely on the medical evidence. See 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).

Where medical evidence is in conflict, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). We give greater weight to the opinion of claimant's treating doctor unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find no persuasive reasons not to defer to the treating physicians' opinions.

At the outset, we find that claimant did suffer from a psychological condition, which her treating psychiatrist, Dr. Carter, diagnosed as "major depression, single episode," and which required treatment. (Ex. 71B; see also Exs. 77, 79B-1). He treated claimant with antidepressant medication and both group and individual psychotherapy, as a result of which her psychological condition improved. (Exs. 79A, 79B-1). We note that Dr. Glass, an independent examining psychiatrist, disagreed with Dr. Carter's diagnosis of "major depression," but we do not find his opinion persuasive. His examination took place approximately 4 months after claimant began treatment with Dr. Carter, who stated that she improved steadily with treatment and time. (Exs. 78-9, 78B). Moreover, Dr. Glass believed that continued treatment with antidepressant medication was appropriate, even at the time of his examination. (Ex. 78-9).

The critical question, however, is whether claimant's compensable injury and its sequelae were the major contributing cause of the psychological condition or the need for treatment. We rely on the opinions of claimant's treating psychiatrist, Dr. Carter, as well as the opinion of Dr. McConochie, Ph.D., who examined claimant in February 1990 and referred her for treatment to Dr. Carter.

After examining claimant, Dr. McConochie made the following findings:

> "[Claimant] appears to be suffering from a chronic pain syndrome related to a degenerative back problem which has required repeated surgeries.
>
> "* * *
>
> "[Claimant] appears to be in need of supportive counseling to deal with her chronic back pain and related frustrations. While she seems slow to recognize this need and ask for such help, it is the present examiner's opinion that she is in intense need, and such supportive counseling is recommended." (Ex. 65A-4 to -5).

He found no evidence of any developmental or personality disorder, but opined instead that claimant's "repeated back surgeries suggest a rather serious degenerative back disease which causes chronic pain that is difficult for [claimant] to endure without being very stoic." (Ex. 65A-5).

Dr. Carter began treating claimant on March 29, 1990, and continued to do so on a weekly basis until at least December 1990. (Ex. 79B-1). He opined that claimant "has undergone severe physical and emotional traumata as a result of her industrial injury of October 12, 1984, from which she has permanent residual [sic]." (Ex. 79A-1). He further opined:

> "This lady has had multiple surgeries since her industrial injury of October 12, 1984, from which she has permanent physical residuals. She also carries psychopathology in the form of depression, anxiety associated with panic episodes, post trauma stress disorder, all of which contribute to her experience of chronic pain relative to her injury and residuals." (Ex. 79B-1).

Reading Dr. Carter's opinions together with his initial diagnosis (Exs. 71B, 77) and Dr. McConochie's opinion, we find that claimant's compensable 1984 injury and its sequelae, including repeated surgeries and chronic pain, are the major contributing cause of her current psychological condition and need for psychiatric treatment. In reaching this conclusion, we note that no incantation of "magic words" or statutory language is required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

SAIF argues that we should rely on the opinion of Dr. Glass, an independent psychiatric examiner, who found that claimant's work injury was not the

major contributing cause of her "frustration and unhappiness" at the time of his examination. (See Ex. 78-9). However, we do not find his opinion persuasive. Dr. Glass examined claimant only once, whereas Dr. Carter treated claimant weekly over a period of several months. Dr. Carter disagreed with Dr. Glass' opinion because it was not based on an accurate history or accurate clinical condition of claimant. (Ex. 78B). We find that Dr. Glass' opinion is based on an incomplete medical history in that he did not consider Dr. McConochie's examination and report, which was the basis for claimant's referral to Dr. Carter for treatment. Accordingly, we give Dr. Glass' opinion little weight.

In reaching our conclusion that claimant's compensable injury is the major contributing cause of her current psychological condition and need for treatment, we find that claimant's psychological condition arose as a consequence of her compensable injury. ORS 656.005(7)(a)(A). We are not persuaded that claimant had any preexisting psychiatric condition, which combined with her compensable injury to cause the need for psychological treatment. See ORS 656.005(7)(a)(B). Only Dr. Glass diagnosed preexisting personality disorders, relying on the MMPI report. (Ex. 78-8). Consulting psychiatrists Drs. Thompson and Arnold merely concurred with Dr. Glass' diagnosis after reviewing the medical records. (Exs. 79, 82). However, we do not find these opinions persuasive. Neither Dr. McConochie nor Dr. Carter found underlying personality disorders (Exs. 65A-5, 71B), and claimant never had any prior psychiatric treatment (Tr. 30-31), despite the various traumas in her life. Consequently, we find that claimant's current psychological condition arose as a consequence of her compensable injury.

Aggravation

Claimant is entitled to additional compensation for a worsened condition resulting from the original injury. ORS 656.273(1). To establish a compensable worsening of her unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds, Lucas v. Clark, 106 Or App 687 (1991).

Claimant sought psychological treatment after she began working in a clerical position in November 1989, initially only 2-4 hours per day. (Ex. 65A-5). Dr. Carter stated that as a result of the psychiatric treatment, claimant was able to retain her job and receive a promotion to a full time position with a salary increase. (Exs. 79A, 79B). Thus, we conclude that although claimant's psychological condition is compensably related to her low back condition, it did not result in diminished earning capacity. Accordingly, claimant has not sustained a compensable aggravation as a result of her psychological condition.

Attorney Fees

Claimant is entitled to an assessed attorney fee for her counsel's services at hearing and on review concerning the compensability issue. 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 $3,000 is a reasonable fee, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's brief), the value of the interest involved, the complexity of the issue, and the risk that claimant's attorney may go uncompensated.

ORDER

The Referee's order dated April 15, 1991 is reversed in part and affirmed in part. To the extent that the SAIF Corporation denied the compensability of

claimant's psychological condition, the denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $3,000, payable by SAIF. To the extent that SAIF denied an aggravation claim, that portion of the denial is upheld. The remainder of the Referee's order is affirmed.

March 20, 1992 Cite as 44 Van Natta 484 (1992)

In the Matter of the Compensation of
SHIRLEY J. SANDERSON, Claimant
WCB Case No. 91-02310
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Harri's order which: (1) awarded claimant temporary partial disability commencing February 5, 1991; (2) assessed a penalty of 25 percent for the employer's allegedly unreasonable termination of claimant's temporary disability; and (3) awarded a $250 carrier-paid attorney fee for the employer's unreasonable resistance to the payment of temporary disability compensation. On review, the issues are temporary partial disability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

We adopt the Referee's reasoning and conclusions as to claimant's entitlement to temporary partial disability compensation with the following comment.

On review, the employer argues that claimant is not entitled to temporary disability compensation because she did not seek authorization from her treating physician for time loss benefits. We disagree with the employer's analysis. Former OAR 436-60-030 (4)(a) and (b) provide for payment of temporary total disability under circumstances when the physician verifies that a worker cannot continue working or the job offer is withdrawn. These qualifying events are stated in the alternative.

Here, we agree with the Referee's conclusion that the employer effectively withdrew its offer of modified work by advising claimant that there were no other modified jobs available, other than the modified job that was beyond her physical limitations. Consequently, we conclude that claimant was entitled to temporary total disability upon leaving her employment on February 5, 1991. However, like the Referee, we also conclude that, by virtue of claimant's receipt of unemployment insurance benefits, the employer was entitled to reduce claimant's disability benefits for any period coinciding with her receipt of the unemployment benefits. See Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987); Roberta L. Jones-Lapeyre, 43 Van Natta 942 (1991).

Penalties and Attorney Fees

We note here that claimant requested a hearing in this matter after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, we apply the 1990 amendments to the workers' compensation law. Or Laws 1990 (Special Session), ch. 2, section 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee found that the employer had unreasonably refused to pay claimant's temporary disability compensation and awarded claimant a penalty with one-half of the penalty payable to claimant's counsel under ORS 656.262(10). The Referee also awarded claimant's counsel a $250 assessed fee pursuant to 656.382(1) for the employer's unreasonable resistance to payment of the temporary disability compensation.

Subsequent to the Referee's order, we held that, when the factual basis in support of the penalty under ORS 656.262(10) is identical to the factual basis for which an attorney fee under ORS 656.382(1) might be awarded, the simultaneous assessment of an attorney fee and a penalty would contravene the legislative intent expressed in amended ORS 656.262(10) that the claimant's attorney receive one-half the penalty "in lieu of an attorney fee." Nicolosa Martinez, 43 Van Natta 1638 (1991). That is the case here. Under such circumstances, claimant's attorney is not entitled to an attorney fee under ORS 656.382(1) in addition to the penalty award. Accordingly, we reverse the Referee's $250 assessed fee award.

Attorney Fees on Review

Because the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable assessed attorney fee for claimant's counsel's services on review concerning claimant's entitlement to temporary disability is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved. In doing so, we note that claimant is not entitled to an attorney fee for services on review concerning the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The Referee's order dated June 21, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that awarded an assessed fee of $250 is reversed. The remainder of the order is affirmed. For services rendered on Board review concerning the temporary disability issue, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

March 20, 1992 Cite as 44 Van Natta 485 (1992)

In the Matter of the Compensation of
RALPH D. STINSON, JR., Claimant
WCB Case No. 90-20604
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Steven R. Cotton (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Michael V. Johnson's order which: (1) upheld the SAIF Corporation's denial of the compensability of claimant's medical services claims for treatments provided on June 7, 1990 and June 11, 1990; and (2) declined to assess a penalty and a related fee for allegedly unreasonable claim processing. On review, the issues are compensability of medical services and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction in the fourth full paragraph on page 2 of the Opinion and Order:

> "Independent medical examiners subsequently referred to claimant's slipping incident as 'it appeared to be a rather trivial event causing temporary back pain with temporary increase in the examinee's symptoms, but not resulting in any permanent injury.'" (Ex. 9) (emphasis for correction).

CONCLUSIONS OF LAW AND OPINION

The Referee found that the medical treatment claimant received on June 7 and June 11, 1990 was not due in material part to his compensable low back condition, but was due instead to an off-work incident on June 3, 1990, when claimant slipped and fell while fishing. The Referee further reasoned that SAIF denied only medical treatment on those dates, on the ground that the treatment was not related to the compensable injury. We agree.

At the outset, we find that although the issue in this case involves medical services, we have jurisdiction over this matter. In Michael A. Jaquay, 44 Van Natta 173 (1992), we held that there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical services. Accordingly, where a denial is based on the ground that the need for medical services is not causally related to the compensable injury, the Board has jurisdiction. Michael A. Jaquay, supra.

An injured worker is entitled to medical services "for such period as the nature of the injury or the process of recovery requires, including such medical services as may be required after a determination of permanent disability." ORS 656.245(1)(a). In order to establish compensability of medical services, claimant must show that his compensable low back condition was materially related to his need for medical services on June 7 and June 11, 1990.

We agree with the Referee that claimant has failed to show that his compensable low back condition was a material contributing cause of his need for medical treatment in June 1990. Dr. Barnes, claimant's family physician, treated him on the two dates in question. He opined that the slip and fall injury on June 3, 1990 was a new injury, "probably not related to the [compensable] September 1989 injury." (Ex. 8).

Claimant's attending neurosurgeon, Dr. White, opined that claimant's low back condition had "improved and stabilized by the time of his slip/fall incident while fishing." (Ex. 15).

Under these circumstances, we conclude, as did the Referee, that the sole reason for claimant's treatment by Dr. Barnes on June 7 and June 11, 1990 was due to the slip and fall incident while fishing. Accordingly, we find that claimant's compensable low back condition was not a material contributing cause of the need for treatment on the two dates in question.

Claimant also argues that he is entitled to a penalty and related attorney fees for SAIF's unreasonable denial of compensation for medical services. ORS 656.262(10); 656.382(1). However, because we have found that the medical treatment claimant received on June 7 and June 11, 1990 was not compensably related to his work injury, it follows that SAIF's denial was not unreasonable, nor did SAIF unreasonably resist the payment of compensation. Therefore, we find that claimant is not entitled to a penalty or related attorney fees. Ellis v. McCall Insulation, 308 Or 74, 78 (1989).

ORDER

The Referee's order dated May 10, 1991 is affirmed.

In the Matter of the Compensation of
SACHA C. KREBS, Claimant
WCB Case No. 91-03582
ORDER ON REVIEW
Clayton C. Patrick, Claimant Attorney
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Livesley's order that: (1) set aside its denial of claimant's low back injury claim; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

SAIF first argues that claimant failed to prove her claim with medical evidence supported by objective findings, as required by ORS 656.005(7)(a). Specifically, SAIF contends that none of the medical findings satisfy our construction of ORS 656.005(7)(a) in Suzanne Robertson, 43 Van Natta 1505 (1991) except for the MRI finding of a minimal disc bulge, and that finding was not proven to be attributable to claimant's employment conditions.

In Robertson, we construed the "objective findings" requirement to be satisfied if a physician examines the worker and, based on that examination, finds that the worker suffers from a disability or a physical condition that requires medical services. 43 Van Natta 1505, 1507 (1991). This evaluation may be based on the worker's description of the pain that she is experiencing, although the report cannot merely recite the claimant's complaints of pain and must indicate that the claimant does, in fact, experience symptoms. Id.

In this case, Dr. Howard, M.D., who treated claimant in the emergency room, noted "tenderness to palpation over the posterior spinous processes[.]" (Ex. 3). Dr. Sinclair, claimant's treating physician, noted "pain in the L4-L5 region around the vertebral column and in the paraspinal areas." (Ex. 4). Dr. Purtzer, who saw claimant on referral from Dr. Sinclair, noted "diffuse tenderness throughout the back." (Ex. 7-2). In each case, the physicians either treated claimant with medication for her back pain or recommended treatment. There was no indication that the physicians believed that claimant did not actually experience her symptoms.

The only contradicting evidence is from an independent medical evaluation by Dr. Brooks, neurologist, and Dr. Coletti, orthopedist. They found evidence of functional overlay and stated that claimant's "subjective complaints are out of proportion to the objective findings." (Ex. 9-5). We conclude, however, that this report does not overcome the reports of the treating physicians. See Vincent A. Lopez, 44 Van Natta 29, 31 (1992). We therefore conclude that claimant carried her burden of proof under ORS 656.005(7)(a).

SAIF next asserts that claimant's testimony at hearing and her statements to the physicians were sufficiently inconsistent that she should not be found credible.

Because the Referee's credibility finding was based on demeanor, we defer to his determination that claimant was credible. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Moreover, we disagree with SAIF that the substance of claimant's testimony directly conflicts with documentary evidence and the testimony of other witnesses. For instance, SAIF disputes claimant's contention that she frequently bent over to pick up wires from off the floor.

SAIF points out that, according to the testimony of co-workers, it was rarely or never necessary to retrieve wires from the floor.

Claimant testified that her wire supply was on the floor and that she was required to pick up three small wires and piece them into the cable that she was constructing. (Tr. 34- 35). Claimant also explained that only she was required to get wire from the floor because her co-workers had wire hanging from their work stations. (Tr. 114). Testimony by Michael Pithan and Bill George, claimant's co-workers, did not contradict these statements. Although they stated that they were not required to pick up wire from the floor unless it was salvageable, (Tr. 88, 97), Pithan and George testified that that they did not know if claimant had to pick up wires from the floor, (Tr. 88, 102). Moreover, both Pithan and George testified that they saw claimant crying and complaining that she had hurt her back. (Tr. 88-89, 103). Claimant's testimony that she handed wires to Pithan and George were directly denied by both men; however, we do not find that this one inconsistency should discredit claimant's entire testimony.

We also disagree with SAIF's contention that claimant's description of her symptoms differed in her histories to the physicians and her testimony at hearing. In each instance, claimant consistently related that she had sudden onset of pain when bending over to pick up a wire and that the pain radiated into her legs and into her upper back, creating a tingling sensation in her toes. Claimant also consistently stated that, although intermittent, the pain in her legs improved. In light of this statement, we ascribe little weight to claimant's comments to Dr. Sinclair that she had no pain in her legs. Moreover, we do not find that claimant's testimony that she paused before standing when she injured her back contradicts Dr. Sinclair's report that claimant was "unable to get up for a certain amount of time." (Ex. 4).

Finally, we address SAIF's contention that the Referee incorrectly discounted the testimony of Angela McCormick, who stated that she saw claimant injure her hand by punching a Tampax machine in the company bathroom, then overheard claimant tell her co-workers that she had injured her hand by slipping in water in the bathroom. (Tr. 70-71). McCormick did not report this incident until several months later. Claimant denied McCormick's testimony. (Tr. 113).

We agree that McCormick's testimony has some bearing on the compensability of the claim. We find, however, that this testimony does not outweigh evidence indicating that claimant injured her back at work and that her job was a material contributing cause of her injury. This evidence consists of claimant's testimony, corroborated by Pithan and George, that she felt back pain in the middle of her shift and that her mother came and took her to the emergency room. Claimant consistently reported to all the physicians that she felt a sudden onset of pain while bending over to pick up a wire. Claimant proved that she suffered from a lumbar strain. We conclude that claimant proved the compensability of her claim.

Penalty

The Referee assessed a penalty under ORS 656.262(10)(a), concluding that, even if SAIF's denial was not initially unreasonable at the time it issued on February 21, 1991, it became unreasonable once the May 21, 1991 MRI indicated a minimal disc bulge, (Ex. 10).

At the time that SAIF denied the claim, the medical evidence only showed that the physicians had found tenderness in claimant's back. Although an x-ray had been performed, it showed no abnormalities, (Ex. 2). In light of the fact that our order in Suzanne Robertson, supra, did not issue until after the hearing, we conclude that SAIF was not unreasonable in denying the claim for lack of

medical evidence supported by objective findings. Moreover, we find that the MRI did not render the denial unreasonable. Although the MRI did disclose a minimal disc bulge, there was no indication that the bulge caused claimant's symptoms or was itself caused by her work. We therefore reverse the Referee's assessment of a penalty under ORS 656.262(10)(a).

Under ORS 656.382(2) claimant's attorney is entitled to a fee for services before the Board on review concerning compensibility. 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 is $750, to be paid by the SAIF Corporation. 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 July 10, 1991 is affirmed in part and reversed in part. That portion of the order that assessed a penalty under ORS 656.262(10(a) for an allegedly unreasonable denial is reversed. For services on Board review, claimant's counsel is awarded an assessed fee of $750, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

March 23, 1992 Cite as 44 Van Natta 489 (1992)

In the Matter of the Compensation of
VICTORIA M. LONG, Claimant
WCB Case No. 90-08366
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Galton's order that upheld the insurer's denial of claimant's occupational disease claim for toxic exposure. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the second paragraph and instead provide the following supplementation.

Fruit is stored in controlled atmosphere (CA) rooms. After the rooms are sealed, oxygen is removed and replaced with nitrogen. (Ex. 16-3, Tr. 74-75). Before the rooms are again opened, the nitrogen is then pumped out through ceiling vents. (Tr. 75).

A solution containing sodium lignosite, a wood by-product, is used to float some fruit to the packing tables. (Ex. 16-3, Tr. 81-82). Before reaching the packers, the fruit goes through a rinse, then a series of fans, and finally sponges. (Tr. 82). The fruit is edible once it reaches the packers. (Tr. 83).

Chlorine has not been used in the packing plant in several years. (Ex. 16-2, Tr. 83). When it was used, diluted chlorine was used as a disinfectant in the dump tank, where fruit was placed before going through the process explained above. (Id.)

A hydro cooler is used for cherries; ammonia is the coolant solution and is contained in sealed pipes. (Tr. 77-78). Neither phosgene nor nitrous oxide is used in the plant. (Tr. 84).

On July 13, 1989, the plant experienced an ammonia leak during the swing shift. Claimant was not working at that time and she refused to work the following day. (Tr. 79-80).

CONCLUSIONS OF LAW AND OPINION

Claimant must prove that employment conditions were the major contributing cause of her disease or its worsening before her claim for an occupational disease can prevail. ORS 656.802(2). In attempting to carry this burden of proof, claimant relies on medical opinion by her treating physician, Dr. Keppel, who specializes in pulmonary disease. Keppel found that claimant suffered from dyspnea, or shortness of breath, as a result of repeated inhalations of toxic gas. (Tr. 9). Keppel "suspected" that chlorine would be the most likely toxin to have caused claimant's condition, although he found that phosgene and nitrous oxide could also be factors. (Tr. 10).

The record also contains opposing medical opinion indicating that claimant showed no evidence of cardiopulmonary disease, (Ex. 15-3), or damage to the lungs indicating a toxic gas inhalation, (Ex. 18-38).

When the medical evidence is divided, we give greater weight to the conclusion of claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 801, 814 (1983). In this case, we find persuasive reasons not to give great weight to Dr. Keppel's opinion. In determining that claimant had been exposed to toxic gases, Keppel relied only on claimant's report of the packing plant's use of chemicals. Although she asserted that chlorine and other chemicals were used in the plant, claimant demonstrated that she had no real knowledge of the chemicals that were actually in use, testifying that she never saw any labels and only spoke to cleaning people. (Tr. 62-63).

Moreover, there was evidence that the packing plant had not used chlorine in a number of years; this was the agent that Keppel suspected was the most likely cause of claimant's condition. Of the materials that were shown to have been used, claimant failed to demonstrate that she was exposed or inhaled any chemical fumes.

We are persuaded that Keppel relied on information regarding working conditions that was either inaccurate or, at best, speculative. We therefore find that his opinion is not persuasive. Because the remaining evidence shows that claimant's condition has no connection with her work, we conclude that she failed to prove a claim for occupational disease.

ORDER

The Referee's order dated June 10, 1991 is affirmed.

March 23, 1992 Cite as 44 Van Natta 490 (1992)

In the Matter of the Compensation of
PATSY O'BRYANT, Claimant
WCB Case No. 90-05638
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Gruber's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back condition from 44 percent (140.8 degrees), as awarded by a Determination Order, to 59 percent (188.8 degrees). On

review, the issue is extent of unscheduled permanent disability, up to and including permanent total disability.

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

Claimant first contends that she is permanently and totally disabled. Claimant relies on medical reports stating that she likely will not ever perform "substantial gainful work," (Ex. 38A), and that claimant is incapable of performing "regular work on a full time basis," (Ex. 39A). These conclusory statements are not sufficient to overcome the medical evidence proving that claimant is not totally disabled, either physically or in combination with non-medical factors. We therefore conclude that the Referee was correct in determining that claimant is not entitled to permanent total disability.

Claimant next contends that she is entitled to a total of 76 percent unscheduled permanent partial disability, as opposed to the 59 percent awarded by the Referee. Claimant argues, first, that she proved a chronic condition limiting repetitive use of her cervical spine, entitling her to 5 percent additional impairment. Claimant relies only on her own testimony to prove a chronic condition limiting repetitive use of her cervical spine. Without medical opinion documenting such a condition, claimant's testimony alone is not sufficient to entitle her to an award under former OAR 436-35-420(4). Ruben D. Carlos, 43 Van Natta 605, 607 (1991). Claimant therefore failed to prove her entitlement to an award for a chronic condition limiting repetitive use of her cervical spine.

Claimant also asserts that she proved a compensable degenerative disc disease, entitling her to 4 percent additional impairment under former OAR 436-35-350(2), which provides for 4 percent for "any unoperated rupture bulge or other disc derangement." Claimant contends that the medical evidence shows that she has a degenerative disc disease at C5-6 that was aggravated by her injury.

We agree that a report from the Western Medical Consultants dated April 7, 1987 diagnosed "degenerative disc disease, C5-C6 with superimposed cervical strain." (Ex. 4G-4). That diagnosis was repeated in a January 30, 1989, report from the Western Medical Consultants. (Ex. 6-5). However, in this later report, the Consultants do not suggest any continuing relationship between the compensable injury and the disc condition. Nor is such a relationship corroborated by any other medical opinion, including the most recent report on February 7, 1990, from the Western Medical Consultants (Ex. 31), an evaluation from the Northwest Pain Center (Ex. 18), and her treating physician, Dr. Jones, M.D. (Ex. 38). In view of the lack of corroboration, we find the earlier reports insufficient to prove a continuing relationship between the degenerative disc disease at C5-C6 and claimant's compensable injury. Therefore, even assuming that such a condition falls under former OAR 436-35-350(2), we conclude that claimant has failed to prove impairment under this rule. See Alton H. Shotwell, 43 Van Natta 2421 (1991).

Finally, claimant contends that she is entitled to a training value of +1 under former OAR 436-35-300(5). Claimant argues that, although she has shown competence in the specific vocational pursuit of a certified nurse's aide, her disability prevents her from using that competence in a job.

Former OAR 436-35-300(5)(b) provides that, "[f]or workers who do have competence in some specific vocational pursuit, no value shall be allowed." We have interpreted "specific vocational pursuit" to mean employment other than an entry-level position. See Larry L. McDougal, 42 Van Natta 1544 (1990). Furthermore, we apply the rule if the claimant has training in a specific vocational

pursuit even though such pursuit is no longer within the claimant's physical capabilities. Jimmie L. Wilson, 42 Van Natta 2526, 2528 (1990).

Here, claimant obtained her certificate to become a nurse's aide. Because she acquired formal training, we find that she had competence in a specific vocational pursuit. Consequently, claimant is not entitled to a training value of +1 even if she no longer has the physical capabilities to perform as a certified nurse's aide.

ORDER

The Referee's order dated February 1, 1991 is affirmed.

In the Matter of the Compensation of
DONALD J. POWELL, JR., Claimant
WCB Case No. 90-0443S
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Daughtry's Order on Attorney Fees that approved the payment of an attorney fee out of a prior Determination Order award of unscheduled permanent disability. On review, the issue is attorney fees.

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

Claimant contends that his former attorney should not be compensated out of his permanent disability benefits as awarded by an October 4, 1989 Determination Order, because "[i]t is not customary to do so." Claimant cites no legal authority to support his contention that the Referee's attorney fee award is improper. We conclude that the attorney fee award was, in fact, proper.

An award of attorney fees in a worker's compensation case is proper when expressly authorized by statute. Forney v. Western States Plywood, 297 Or 628 (1984). Ins this regard, ORS 656.386(2) provides that:

> "In all other cases attorney fees shall continue to be paid from the claimant's award of compensation except as otherwise provided in ORS 656.382.

OAR 438-15-030 provides:

> "If an attorney is instrumental in obtaining compensation for a claimant without a hearing before a referee, a reasonable attorney fee may be approved. The amount of the fee shall be determined by a referee or by agreement of the parties."

Here, the insurer issued a Notice of Closure in 1985 awarding temporary disability benefits, but no permanent disability. On September 9, 1988, claimant signed an "agreement for legal services" to be provided by his former attorney, i. e., a retainer agreement.

After several correspondences between claimant's former attorney and the insurer over a period of approximately one and one half years, the insurer

requested and the Evaluation section issued a Determination Order which awarded claimant 11 percent (35.2 degrees) unscheduled permanent partial disability on October 4, 1989. In this regard, claimant concedes in his appellate brief that his former attorney "did provide valuable services to the claimant . . . " in this matter.

Therefore, we find that claimant's former attorney's efforts on behalf of his client were instrumental in obtaining additional compensation in the form of permanent partial disability. Accordingly, we conclude that the Referee correctly awarded an approved attorney fee of 25 percent, not to exceed the requested fee of $838.05, to be paid out of the increased compensation awarded to claimant by the October 1989 Determination Order.

ORDER

The Referee's order dated June 19, 1991 is affirmed.

In the Matter of the Compensation of
GEORGE T. COOPER, Claimant
WCB Case No. 91-05718
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Emerson's order that dismissed his request for hearing. The insurer has moved the Board for an order striking claimant's reply brief. On review, the issues are motion to strike and jurisdiction. The motion to strike is denied and the Order of Dismissal is affirmed.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and the parties' stipulated facts. We add the following supplementation.

Claimant did not file an appellant's brief. The insurer filed a respondent's brief and requested that the Referee's order be affirmed. Claimant timely filed a reply brief, discussing the Referee's order and contending that it should be reversed.

CONCLUSIONS OF LAW AND OPINION

Motion to strike

The insurer objects to claimant's reply brief and contends that, because claimant failed to submit an appellant's brief, it has had no opportunity to respond to the arguments raised by claimant. The insurer, therefore, requests that we strike claimant's reply brief.

We would agree with the insurer if this case involved a situation in which neither an appellant's nor respondent's brief had been filed. Under such circumstances, there is nothing upon which to rely. See Alvin L. Woodruff, 39 Van Natta 1161 (1987). Moreover, we would agree that untimely filed appellant's briefs that are resubmitted in reply to cross-appellant's briefs should not be considered. See Deryl E. Fisher, 38 Van Natta 982 (1986).

However, the insurer chose to file an expressly entitled "Respondent's Brief." Consequently, we do not find that claimant's brief was "in lieu" of an appellant's brief. Rather, the brief was in reply to the insurer's "Respondent's Brief." Had the insurer wished to merely rely upon the Referee's reasoning, it could have done so in a letter, specifically waiving its opportunity to submit a brief. Yet, because the insurer chose to file a "Respondent's Brief," claimant was entitled to file a reply. See Virgil Brogan, 40 Van Natta 67 (1988).

Inasmuch as the reply brief was not a resubmitted appellant's brief and was timely filed, it will be considered on Board review. Accordingly, the motion to strike claimant's reply brief is denied.

Dismissal

The Referee concluded that he had jurisdiction over this matter because the procedure provided by ORS 656.245(1)(b) (i.e. for a treating physician to request the Director's authorization for appropriate palliative care) had been exhausted by the only person entitled to invoke the procedure. The Referee found, therefore, that this matter concerned a claim over which the Hearings Division had jurisdiction. The Referee nevertheless concluded that he was without authority to grant claimant the legal relief he sought pursuant to ORS 656.245(1)(b), and he therefore dismissed claimant's request for hearing.

Subsequent to the Referee's order, we concluded that, pursuant to amended ORS 656.245, the Hearings Division does not have jurisdiction to determine issues regarding entitlement to palliative care. Robert D. Cox, 43 Van Natta 2726 (1991).

Amended ORS 656.245, which addresses compensability of palliative care, in pertinent part, provides:

> "(b)***if the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment***"

Here, the Referee found that claimant's treating physician, Dr. Pearson, petitioned the insurer, but then elected to go no further. In other words, Dr. Pearson did not request Director approval under the procedure provided by ORS 656.245(1)(b). Under the circumstances, we find that ORS 656.245 provides a procedure for the resolution of such a dispute and we conclude that this case does not present a matter concerning a claim. Cox, supra. Accordingly, original jurisdiction lies exclusively with the Director. Stanley Meyers, 43 Van Natta 2643 (1991).

Inasmuch as the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we find that the Referee properly dismissed claimant's hearing request.

ORDER

The Referee's order dated July 16, 1991 is affirmed.

In the Matter of the Compensation of
CORINNE K. FREEMAN, Claimant
WCB Case No. 91-01239
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee McWilliams' order which: (1) set aside a Determination Order that found that claimant's claim remained nondisabling; and (2) found that claimant had not perfected an aggravation claim. On review, the issues are reclassification and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSION OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Reclassification

We adopt the Referee's reasoning and conclusions regarding the issue of the reclassification of claimant's claim from nondisabling to disabling status with the following supplementation.

Claimant argues that former ORS 656.262(6)(b) applies in her case because she requested reclassification on June 25, 1990, before the 1990 amendments became effective. She argues that this statute did not have a one year limitation. As noted above, the 1990 amendments apply to claimant's claim. Furthermore, the statute to which claimant refers deals with requirements for a notice of acceptance or denial.

Here, claimant did not seek reclassification of her injury from nondisabling to disabling within one year of her injury; therefore, the claim must be made as an aggravation claim pursuant to ORS 656.273. See Or Laws 1990 (Special Session), ch. 2, 48(2). The Evaluation Section had no jurisdiction to determine whether the nondisabling claim had become disabling. Accordingly, we agree with the Referee that the August 2, 1990 Determination Order should be set aside as void.

Aggravation

The Referee found that claimant had not presented a claim for aggravation because the physician's report contained no objective medical findings. Although we agree that claimant has failed to make a claim for an aggravation under current ORS 656.273(3), we do so for different reasons. That statute states:

"A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation."

To establish an aggravation claim, "the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened." Glean A. Finley, 43 Van Natta 1442, 1444 (1991); Herman M. Carlson, 43 Van Natta 963, 964 (1991). This report must establish a causal connection between claimant's noted condition and compensable injury. Carlson, supra, at 964; Michael L. Page, 42 Van Natta 1690, 1693 (1990).

After the Referee issued her order, we decided Suzanne Robertson, 43 Van Natta 1505 (1991), in which we held that "objective findings" may be based on a physically verifiable impairment, but may also be based on a physician's evaluation of the worker's description of the pain that she is experiencing. See also Jacqualyn L. Hetrick, 43 Van Natta 2357 (1991); Robert E. Leatherman, 43 Van Natta 1678 (1991). On April 18, 1991, Dr. Adamo, M.D., examined claimant. (Ex. 9A). His evaluation of claimant's subjective complaints of ongoing pain in her right arm and tingling in her right hand with heavy use of her right arm constitutes "objective findings."

However, his report does not establish that claimant's right arm condition has worsened. Claimant described this condition as having existed for nearly four years and reported ongoing right arm pain since she first went to a physician about this condition in January 1988. (Exs. B, 3, 4, 9A). Furthermore, Dr. Adamo does not establish a causal connection between the only new symptom, tingling in claimant's right hand with intensive right arm use, and her compensable right shoulder tendonitis. Instead, he opines that this may relate to a different etiology than the tendonitis. (Ex. 9A). On this record, we find that claimant has failed to establish an aggravation claim under ORS 656.273(3).

ORDER

The Referee's order dated May 24, 1991 is affirmed.

March 24, 1992 Cite as 44 Van Natta 496 (1992)

In the Matter of the Compensation of
RAY HAUMAN, Claimant
WCB Case No. C2-00144
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Liberty NW Insurance, Insurance Carrier

Reviewed by Board Members Neidig and Tenebaum

On January 21, 1992, 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.

Here, the agreement contained language which could reasonably be interpreted as purporting to limit claimant's right to medical services under ORS 656.245 for conditions related to the compensable injury. See Roy L. Plumlee, 43 Van Natta 47 (1991). By letter of January 24, 1992, the Board requested the parties correct this deficiency by submitting an addendum within 21 days from the date of the Board's letter. The parties have not submitted an addendum

within the 21-day time period. Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2); Ronald Dunlap, 43 Van Natta 982 (1991). Accordingly, we decline to approve the agreement and return it to the parties.

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

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

IT IS SO ORDERED.

March 24, 1992 Cite as 44 Van Natta 497 (1992)

In the Matter of the Compensation of
DEBRA M. JENNER, Claimant
WCB Case No. 89-21485
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Lipton's order which: (1) set aside its "de facto" denial of claimant's request for surgery for a left ear condition; and (2) assessed penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are compensability, penalties, and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last paragraph contained in the "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant proved that the 1986 injury was a material contributing cause of her left ear condition. The insurer asserts that claimant should be required to prove that her injury was the major contributing cause of her condition because, under Julie K. Gasperino, 43 Van Natta 1151 (1991), claimant's inner ear concussion is a "secondary consequential condition."

Under ORS 656.005(7)(a)(A), "no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." In Julie K. Gasperino, supra, we held that the "major contributing cause" standard required by ORS 656.005(7)(a)(A) applies to "secondarily consequential conditions" while the "material contributing cause" standard remains to prove "primarily consequential conditions."

Here, we find that claimant's condition should be analyzed as a primarily consequential condition. Along with complaints of neck and shoulder pain, claimant reported that she experienced headaches and dizziness shortly after the incident of November 28, 1986. (Ex. 8-1). Claimant reported numbness within two weeks of the incident. (Ex. 13-1). In short, claimant alleges that her symptoms of left ear pain, dizziness, nausea, numbness of the left arm, and

imbalance arose directly from the act of lifting buckets of ice into an ice machine at work rather than as a secondary consequence of the injuries she sustained on that date. Therefore, in order to establish compensability, claimant must show that the November 28, 1986 accident was a material contributing cause of her left ear condition.

Since suffering a cervical strain on November 28, 1986, claimant has been seen and treated by numerous physicians. In regard to causation of claimant's symptoms of left ear pain, dizziness, nausea, imbalance, and numbness, the medical evidence is divided. Claimant's reports of "numbness and tingling of the left upper extremity," as well as headaches, lightheadedness and dizziness were first noted by Dr. Stevland, neurologist, on December 30, 1986. (Ex. 13-1). Dr. Stevland also found that claimant "was prone to daily, fairly severe muscle contraction headaches and intermittent numbness and tingling involving the face and right arm in 1981, symptoms that [claimant] terms was part of a nervous breakdown that subsequently improved." (Id.) In light of this history, Stevland found that claimant's numbness was "functional in origin." (Id. at 2).

On May 15, 1987, the Western Medical Consultants, conducting an independent medical examination, stated that claimant "admits to chronic headaches since a concussion at age 21 years" but that the headaches had become more severe since her injury and that at times were accompanied by mild nausea. (Ex. 23-2). The Western Medical Consultants diagnosed "cervical strain, by history" and "probable vascular headaches, pre-existing." (Id. at 3).

Dr. Grimm, neurologist, who saw claimant on referral from claimant's treating physician on March 16, 1989, noted "diminished hearing, a dysequilibrium, chronic headaches and deep ear pain. There is clearly something that has happened (by mechanisms unknown) of the left inner ear to involve both the vestibular and chochlear portions; this should be attended to by neuro-otologic investigations." (Ex. 53-5). Grimm, however, concluded that her left-sided numbness "is of a conversion type." (Id. at 4).

On August 23, 1989, claimant's treating physician referred her to Dr. Colistro, psychologist, for a psychological evaluation for symptoms of depression. Colistro's report concluded that the results of the evaluation "suggests a very high degree of psychopathology" and that "the presence of [a large functional component] is amply evident[.]" (Ex. 66-3). Colistro further found "a considerable overlay of suffering, the psychologic component to it, which makes it difficult for [claimant] to view her pain objectively and dispassionately." (Id.)

On October 15, 1989, Dr. Epley, neuro-otologist, saw claimant for "continuing headaches, pain and numbness radiating from the back of the neck into the left arm, imbalance, pressure sensation in the left ear and fatigue." (Ex. 72-1). Epley anesthetized claimant's left external auditory canal and found that claimant's symptoms decreased. Epley diagnosed a "possible inner ear concussion syndrome." (Id. at 2). Epley found that, based on the results of anesthetizing the ear, "the canal is a major source of [claimant's] symptomotology. Inasmuch as this trigger point in the canal is located inferiorly, it is probably vagal." (Id.) Epley recommended "transection of Arnold's branch of the vagus nerve in the left ear canal." (Id. at 3).

Dr. Epley subsequently concluded that claimant's "November 28, 1986 injury was a material contributing factor in causing [her] inner ear concussion." (Ex. 76A). He explained that the "most likely manner in which the ear pathology would be caused by the accident would be through increased intrathoracic and intracranial pressure, transmitted through perilymph to cause a perilymph fistula. Lifting, particularly in a awkward position, could cause this." (Ex.

78-2). Furthermore, Epley found it significant that claimant "did not have the vestibular and ear symptoms prior to the industrial accident, and they had their onset immediately afterwards." (Id.)

On February 1, 1990, Dr. Parvaresh, psychiatrist, conducted an independent psychiatric examination. Parvaresh found "no clear evidence of depression" but noted that "psychological factors [are] affecting physical condition" and "anxiety tension state, chronic, moderate." (Ex. 76-6). Parvaresh also noted "cervical strain; possible inner ear concussion syndrome; [and] muscle contraction headaches[.]" (Id. at 7). The report further stated that claimant "has a considerable degree of psychopathology" and that, although not an orthopedist, Parvaresh was "at a loss as to the nature of the accident and how it could cause all the problems which she believes are attributed to it." (Id.) Parvaresh recommended that claimant be evaluated by a second neuro-otologist.

On May 9, 1990, Dr. Hodgson, neuro-otologist, conducted an independent medical evaluation. Although claimant's complaints previously had related only to the left ear, Hodgson found "extreme sensitivity to very minimal ear cleaning on the right side which appeared less so on the left. This reaction was markedly unusual in that there was minimal contact to the ear canal skin eliciting a severe sensation of choking and distress." (Ex. 80-2). Hodgson also stated that it was his "subjective impression during the examination that the dizziness symptoms were greatly exaggerated and out of proportion to the objective findings." (Id.) Hodgson concluded that there was "a marked functional overlay in this patient." (Id. at 3).

In commenting on Dr. Epley's diagnosis, Dr. Hodgson stated that, although he had found "a fine rotary nystagmus [] on positioning indicating some irritation of the inner ear," he failed to see "how this may be presented based on the lifting type injuries she had, as I do not feel there is any evidence of a perilymph fistula present." (Id.) Hodgson concluded that "there is no clear mechanism between sensitivity of [the auricular branch of the vagas nerve on the left side] and the neck injury of November 28, 1986. In other words, I do not feel that the cervical injury on November 28, 1986 is a material contributing factor in the current symptoms relating to the auricular branch of the vagas nerve in the left ear. To further support this feeling, [claimant] has marked similar sensations in the right ear which have no relation to any of her symptoms in the past and has apparently only been described in my examination." (Id. at 4).

Dr. Epley, therefore, is the only physician to directly relate claimant's symptoms of dizziness, nausea, etc., to her work incident. We are not persuaded, however, by his opinion. First, Epley's reports are not based on a complete and accurate history. Contrary to Dr. Stevland's 1986 report, Epley's reports do not mention that claimant experienced more severe numbness, tingling and headaches in 1981, when she suffered from a nervous breakdown. Furthermore, Epley failed to note that claimant, by her own account, had been experiencing chronic headaches since she had a concussion at age 21.

More importantly, Epley does not take into account the possibility that claimant's symptoms could have a psychological component. Dr. Stevland specifically found that claimant's numbness was "functional in origin." (Ex. 13-1). That opinion was reiterated by Dr. Grimm. Moreover, just two months prior to her first visit with Epley, claimant was diagnosed as suffering from "major depression, single episode, severe" and found to have psychological factors affecting her physical condition. (Ex. 66-4). Dr. Parvaresh also found that psychological factors were affecting claimant's physical condition. (Ex. 76-6).

Second, Epley's opinion does not adequately explain how the work incident caused claimant's left ear symptoms. Epley only states that lifting "could"

cause a "perilymph fistula" through "increased intrathoracic and intracranial pressure." (Ex. 78-2). In a deposition, Epley's explanation was even briefer, stating only that claimant damaged the vagus nerve, which runs through the neck, when she strained her neck muscles. (Ex. 85-5). Later, Epley stated that he "presume[d] that as a result of the injury, the vagal nerve system, if we want to call it that, ha[d] become hypersensitive." (Id. at 13).

On the other hand, Dr. Hodgson persuasively testified as to his reasons for concluding that claimant's ear could not have been injured while lifting buckets of ice. Hodgson explained that an inner ear concussion results if the soft tissues within the boney shell of the inner ear are violently shaken, which did not occur during the lifting incident. (Tr. 43-44). In regard to Dr. Epley's statement that claimant had a perilymph fistula, Hodgson again stated that such a condition was normally associated with some type of trauma to the ear, such as a head injury. (Id. at 45).

Having found that Dr. Epley's opinion is not persuasive, it is entitled to little weight. The remaining evidence either provides no opinion as to the causation of claimant's symptoms or indicates that they are due to psychological factors. We therefore conclude that claimant failed to prove that the November 28, 1986 accident was a material contributing cause of her left ear condition. We thus do not address the insurer's contention that the proposed surgery is unreasonable and unnecessary.

Inasmuch as we have found claimant's condition not compensable, it follows that there are no amounts "then due" on which to base a penalty for the insurer's failure to timely respond to the claim. ORS 656.262(10); Lloyd V. Cripe, 41 Van Natta 1774 (1989). Furthermore, since the claim is not compensable, it likewise follows that there has been no unreasonable resistance to the payment of compensation. ORS 656.382(1); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). Accordingly, we reverse the Referee's assessment of a penalty and attorney fee.

ORDER

The Referee's order dated April 17, 1991 is reversed. The insurer's "de facto" denial is reinstated and upheld. The Referee's award of $2,600 to claimant's attorney is reversed. The Referee's award of a penalty and a $400 attorney fee are reversed.

In the Matter of the Compensation of
JOHN A. LOCKWOOD, JR., Claimant
WCB Case No. 91-02464
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Bethlahmy's order which set aside its denial of claimant's claim for a low back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proven a compensable low back injury. We disagree.

In cases involving preexisting conditions, we have held that whether a claim is compensable is a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that he suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of his disability or need for medical treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Claimant's disability or need for medical treatment must be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). Then, if it is determined that there is a preexisting condition and that the condition combined with the injury to cause or prolong disability or need for treatment, claimant is entitled to disability compensation and treatment if the injury was the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B).

Because of claimant's two prior back injuries and his unrelated preexisting degenerative disc disease, we find that the causation of claimant's low back condition is a complex medical question and we require expert opinion to resolve it. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

There are two medical opinions in the record. Dr. Waller, a neurosurgeon, treated claimant for his 1987 compensable back injury. Claimant's 1987 injury resulted in a L5-S1 disc herniation. Dr. Waller planned to perform microdiscectomy surgery, but this surgery was never performed and claimant was subsequently incarcerated. After the onset of his symptoms in January 1991, claimant saw Dr. Waller on January 22, 1991 and January 28, 1991.

On May 21, 1991, Dr. Waller indicated that claimant's current condition involves foraminal stenosis at the L5-S1 disc, the major contributing cause of which is long-term degenerative changes and not claimant's work activities in January 1991. Waller also opined that the major contributing cause of the original disc herniation at L5-S1 was the 1987 injury and any changes since that time are the result of the degenerative process. Dr. Waller did not believe claimant suffered a back strain injury in January 1991.

Dr. Keenen, orthopedist, opined that claimant's mid January activities were both a material contributing cause and the major contributing cause of claimant's need for treatment. Dr. Keenen saw claimant on only two occasions. We find Dr. Keenen's opinion to be unpersuasive. Keenen's initial diagnosis was and continued to be lumbar degenerative disc disease (Exs. 22, 28). Keenen does not explain the relationship between claimant's alleged back strain and his preexisting degenerative disc disease. Furthermore, he did not mention the possibility of a strain or sprain to claimant's back until approximately three months after his initial evaluation of claimant (Ex. 28). Prior to this time, his diagnostic impression was "preexisting lumbar degenerative disc disease" (Ex. 22).

Although we find the evidence from both doctors to be less than compelling, we find Dr. Waller's opinion to be the most persuasive. He treated claimant after his 1987 injury, and before his January 1991 injury, as well as soon after the January 1991 injury. Therefore, his opinion that claimant did not suffer a back sprain or stain in January 1987 and that the pain claimant experienced was due to long term degenerative changes associated with claimant's preexisting degenerative disc disease has more persuasive force. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Accordingly, we conclude that claimant has not met his burden to prove that he suffered a back strain or sprain injury January 1991 which was a material contributing cause of his disability or need for medical services.[1]

ORDER

The Referee's order dated June 24, 1991 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

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1 Because we have adopted Dr. Waller's opinion that claimant did not suffer a work related back strain in January 1991, it necessarily follows that there was no work injury which "combined" with claimant's preexisting disease to cause disability, within the meaning of ORS 656.005(7)(a)(B). Therefore, the major contributing cause test of that statute did not apply in this case. Nonetheless, claimant has failed to establish the compensability of his claim under the material contributing cause test which did apply.

In the Matter of the Compensation of
CHERIE L. MORAN, Claimant
WCB Case No. 90-16097
ORDER ON RECONSIDERATION
Myrick, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The self-insured employer requested reconsideration of that portion of our February 14, 1992 Order on Review which affirmed the Referee's award of a penalty for an allegedly unreasonable denial. On March 2, 1992, in order to fully consider the matter, we abated our prior order and granted claimant an opportunity to respond. After receiving claimant's response, and further considering the matter, we make the following conclusions.

We adopt the Referee's conclusions and reasoning concerning the penalty issue with the following supplementation.

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

At the time the employer issued its denial, the only medical evidence available indicated that claimant's right foot condition was related to her work activities. (Ex. 1-2). Accordingly, we conclude that the employer's denial was unreasonable. Therefore, we agree with the Referee that a penalty is appropriate in this instance.

Moreover, since the basis for the penalty is an unreasonable denial, we agree that the penalty should be based on the amounts of compensation payable as a result of the Referee's order. See Wacker Siltronic Corp. v. Satcher, 91 Or App 654 (1988).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 15, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DALE G. NODINE, Claimant
WCB Case No. 91-00616
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Podnar's order which found that claimant was not entitled to an assessed attorney fee for his counsel's services in obtaining a pre-hearing rescission of the insurer's compensability denial. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

In November 1990, the insurer prepared an 801 claim form, alleging that claimant suffered an October 1990 low back sprain. In November 1990, claimant's attorney sent the insurer a letter objecting to the hourly wage provided for claimant in the 801 form. On January 9, 1991, the insurer denied claimant's October 1990 injury claim. On January 14, 1991, claimant's attorney filed a hearing request contesting the insurer's January 9, 1991 denial of claimant's low back sprain injury claim. On January 28, 1991, the insurer accepted claimant's "lumbar strain/L4-5 disc." The insurer also notified claimant that it was authorizing Dr. Brett's surgery request.

On March 12, 1991, the insurer responded to claimant's hearing request, contesting that claimant had sustained a work-related injury or occupational disease. On March 18, 1991, the insurer amended its response, admitting that the claim was compensable.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available for the insurer's rescission of its denial. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, section 3. Such is the case here.

The insurer contends that claimant's attorney was not instrumental in obtaining compensation for claimant. We disagree.

The record indicates that the insurer initially denied claimant's October 1990 injury claim on January 9, 1991 (Ex. 14), based on witness statements provided by the employer (Tr. 44). Claimant's attorney filed a request for hearing on January 14, 1991. Prior to this request, claimant's attorney had also notified the insurer of claimant's objection to the hourly wage listed in the 801 claim form. Following its denial, the insurer then conducted its own investigation, but was unable to verify the employer's witness' statements. As a result of its follow-up investigation, the insurer decided it did not have a firm basis for its denial. (Tr. 44-45). Consequently, the insurer then rescinded the denial and accepted the claim on January 28, 1991. (Ex. 14A).

Considering claimant's attorney's November 1990 letter and January 14, 1991 hearing request, and the insurer's January 28, 1991 acceptance, we conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. Under these circumstances, we conclude that claimant is entitled to an assessed attorney fee under ORS 656.386(1).

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of services), the minimal complexity of the issue, and the risk that claimant's attorney would go uncompensated. Under these circumstances, we conclude that a $500 assessed attorney fee is reasonable.

ORDER

The Referee's order dated April 18, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that declined to award an assessed attorney fee pursuant to ORS 656.386(1) is reversed. For claimant's counsel's pre-hearing services which were instrumental in obtaining compensation for claimant without a hearing, claimant's attorney is awarded a reasonable assessed attorney fee of $500, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
BETTY J. RETHERFORD, Claimant
WCB Case No. 90-02078
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Fink's order which: (1) upheld the insurer's partial denial of his claim for a low back condition at L4-5; (2) declined to assess penalties and attorney fees for an alleged failure to properly process a request for surgery at L4-5; (3) declined to find that claimant was entitled to interim compensation from October 26, 1989 to present; and (4) declined to assess penalties and attorney fees for an alleged failure to pay interim compensation. On review, the issues are compensability, interim compensation, penalties and attorney fees.

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

Compensability

Claimant contends that she has established that her L4-5 condition is a compensable component of her accepted March 1984 claim. We disagree.

Dr. Newby, who examined claimant at the time of her original 1984 injury and also performed her previous surgeries at L5-S1, opined that claimant's present need for surgery was unrelated to her March 1984 injury. (Ex. 56). Further, the opinion of the Orthopaedic Consultants was that claimant's degenerative changes at L2-3 and L4-5 were not related to the March 1984 injury. (Ex. 45-6). Inasmuch as we agree with the Referee that Dr. Berkeley's opinion

is not persuasive, we conclude, based on the remaining medical evidence, that the Referee correctly upheld the insurer's January 23, 1991 denial.

Interim Compensation

In Doris A. Pace, 43 Van Natta 2526 (1991), we held that a carrier's obligation to pay interim compensation under ORS 656.273(6)(b) was not triggered until receipt of medical verification of an inability to work.

Here, claimant contends that the insurer received notice of her medically verified inability to work when Dr. Berkeley reported on March 21, 1990 that she was "totally disabled" when he examined her on October 26, 1989. (App. Br. at 9). We disagree.

Dr. Berkeley's time loss authorization was retroactive. Therefore, time loss could not be triggered until receipt of such notice. ORS 656.273. Further, although Dr. Berkeley reported that claimant was totally disabled in October 1989, the facts demonstrate that claimant was, in fact, working in October 1989. Therefore, claimant would not be entitled to interim compensation or temporary disability benefits. Cutright v. Weyerhaeuser, 299 Or 290, 296 (1985). Moreover, it was unclear from Dr. Berkeley's report whether claimant was disabled "due to" the compensable L5-S1 condition or the noncompensable L2-3 and/or L4-5 conditions.

Penalties and Attorney Fees

In order for unreasonable resistance to compensation to be found, claimant's claim must have been compensable. Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). Inasmuch as we have concluded that the Referee correctly found claimant's claim noncompensable, no penalties or attorney fees are warranted.

ORDER

The Referee's order dated April 25, 1991 is affirmed.

March 25, 1992 Cite as 44 Van Natta 505 (1992)

In the Matter of the Compensation of
ROBERT A. CRAVENS, Claimant
WCB Case No. 91-03764
ORDER ON RECONSIDERATION
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 25, 1992 Order on Review which affirmed the Referee's order that directed SAIF to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Citing Michael E. Morrison, 44 Van Natta 372 (1992), SAIF argues that claimant was precluded from challenging the $145 rate at which claimant's permanent disability award was paid pursuant to the May 24, 1990 Notice of Closure. We disagree.

We find the facts of this case distinguishable from those in Morrison. In Morrison the claimant's injury claim was closed by a Determination Order that awarded a specified dollar amount of compensation for 40 percent scheduled permanent disability. The total award corresponded to a rate of $145 per degree of disability. The claimant requested a hearing regarding that award. By stipulation, the award was increased by a specified dollar amount of compensation for

an additional 10 percent scheduled permanent disability. Again, the additional award corresponded to a rate of $145 per degree of disability. In exchange for the increased award, the claimant's request for hearing was dismissed with prejudice as to all issues raised or raisable, and the permanent disability awards became final by operation of law. After the self-insured employer paid the claimant the awards, the claimant requested a hearing asserting that the awards should have been paid at the rate of $305 per degree.

We held in Morrison that, because the Determination Order was final and the claimant had stipulated to the payment of the additional award at the rate of $145 per degree, the claimant was precluded from asserting that his award should be paid at a higher rate.

In this case, contrary to SAIF's contention, the May 24, 1990 Notice of Closure has not become final by operation of law, nor has claimant stipulated to any amount or rate of scheduled permanent disability compensation. Claimant appealed the Notice of Closure, and judicial review of that notice is currently pending before the Court of Appeals. (WCB Case No. 90-15039; CA No. A72277). Accordingly, Morrison does not apply here, and claimant is not precluded from challenging the rate of compensation awarded for his compensable injury.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's motion for reconsideration. 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 attorney's services on reconsideration of the rate of compensation issue is $200, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's response to SAIF's motion), the complexity of the issue, and the value of the interest involved.

Accordingly, our February 25, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 25, 1992 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
KATI A. HANKS, Claimant
WCB Case No. 90-16204
ORDER OF ABATEMENT
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

On February 24, 1992, we affirmed a Referee's order that declined to award benefits for temporary disability during the period that claimant was not performing her modified work duties due to a labor dispute lock out. In reaching our conclusion, we relied on Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991), for the proposition that, in the absence of legislative direction to the contrary, benefits are not available if the loss of wages results from reasons other than the compensable injury.

On our own motion, we are reconsidering an injured worker's entitlement to benefits for temporary disability when modified work is no longer available for reasons beyond the worker's control. In order to retain jurisdiction over this matter, we abate and withdraw our prior order. The parties may provide further

written comment on this issue within 14 days of this order. Thereafter, this matter will be taken under advisement.

IT IS SO ORDERED.

March 25, 1992 Cite as 44 Van Natta 507 (1992)

In the Matter of the Compensation of
BURTON A. ROCHEFORT, Claimant
WCB Case No. 88-14395
ORDER ON REMAND
Burt, Swanson, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Rochefort, 110 Or App 38 (1991). The court reversed our prior order, Burton A. Rochefort, 42 Van Natta 915, 1704 (1990), which found claimant's occupational disease claim for a right foot condition compensable because he had established that his work activities were a material contributing cause of his increased right foot symptoms. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact and Ultimate Fact" contained in our July 31, 1990 Order on Reconsideration with the following supplementation. Claimant's work activities were not the major contributing cause of a worsening of his underlying right foot condition.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we found that claimant's work activities as a vocational assistant prompted a work-related symptomatic worsening of his preexisting arthritic right foot condition. Inasmuch as claimant had required diagnostic medical services for his increased symptoms, we held that claimant's occupational disease claim was compensable. Consequently, we reversed the Referee's order which had upheld SAIF's denial.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that his work activities were the major contributing cause of his condition or the worsening of his underlying condition. Aetna Casualty co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of a claimant's condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (1992). Considering the existence of claimant's preexisting arthritic condition, we conclude that the causation issue is a complex medical question requiring expert medical evidence to resolve. Uris v. Workers' Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 rev den 300 Or 546 (1986).

Here, Dr. Fitchett, claimant's treating orthopedist, provides the only medical opinion concerning claimant's current condition and its relationship to

his work activities. In Dr. Fitchett's opinion, claimant suffers from a "slow progressive arthritis in his foot that has developed over a number of years without relationship to any specific industrial exposure." Dr. Fitchett acknowledged that claimant's prolonged walking and standing on hard surfaces for the past 5 years as a vocational assistant had worsened or aggravated claimant's symptoms from his arthritic condition. However, Dr. Fitchett concluded that these work activities "did not produce a major and significant increase in the degenerative process" and "did not reflect in any way a causative worsening of [claimant's] condition."

Dr. Fitchett's opinion supports a conclusion that claimant's work activities contributed to an increase in the symptoms from his preexisting arthritic right foot condition. Nevertheless, Dr. Fitchett does not consider claimant's work activities to have produced a worsening of claimant's degenerative condition. Inasmuch as claimant must prove that his work activities were the major contributing cause of his right foot condition or its worsening, we agree with the Referee's conclusion that SAIF's denial must be upheld.

Accordingly, on reconsideration, the Referee's order dated December 20, 1988 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARL A. COX, Claimant
WCB Case No. 90-13458
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Davis' order that awarded claimant benefits for 5 percent (7.5 degrees) scheduled permanent disability for the loss of use and function of each forearm. A June 20, 1990 Determination Order had awarded no additional compensation for permanent disability beyond the November 24, 1989 Determination Order award of benefits for 26 percent (5.72 degrees) scheduled permanent disability for injury to the right middle finger. On review, the issue is extent of permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND REASONING

Claimant contends that the Referee erred in failing to award additional benefits for permanent partial disability for loss of grip strength and sensory loss under former OAR 436-35-110. He relies on an August 23, 1990 chart note, in which Dr. Kuller, the treating physician and surgeon, measured claimant's grip strength as 18 on the right, and 21 on the left, with an expected normal range of 35-40. She also noted that claimant had sensory loss, bilaterally, in the thumbs, index, middle and ring fingers. The insurer responds that Dr. Fuller's chart note is not persuasive and asks the Board to rely on the opinion of Dr. Button, a hand surgeon, who also found diminished grip strength and sensory loss, but discounted the findings due to lack of full voluntary effort and

symptom magnification. However, we find this discount is inconsistent with a record which suggests claimant is highly motivated to work.

When there is a dispute between medical experts, we give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). In this case, Dr. Kuller had treated claimant throughout his disability. She had a much better opportunity to evaluate claimant's condition than did Dr. Button, who examined him on one occasion. Accordingly, we accept the opinion of Dr. Kuller, who does not doubt the validity of claimant's complaints, and conclude that claimant has sustained a permanent loss of grip strength and sensory loss due to his compensable injury.

Claimant contends that his grip strength and sensory loss should be rated under former OAR 436-35-110(3)(a), which provides ratings for such impairments due to nerve damage. After our review of the record, however, we are unable to determine whether claimant's compensable impairments are, in fact, due to nerve damage; the loss may be due to atrophy from disuse. Accordingly, we rate his loss of grip strength under the more general provision of former OAR 436-35-110(3)(d). For the same reason, we rate his sensory loss under former OAR 436-35-110(1).

Dr. Kuller reported that claimant's expected grip strength should be "around 35-40." (Ex. 54B). We average those figures for a mean of 37.5. Based on Dr. Kuller's grip strength findings of 18 on the right and 21 on the left, claimant retains 48 percent and 56 percent of grip strength, respectively. He is entitled to benefits for 24 percent scheduled permanent disability for his right forearm and 23 percent scheduled permanent disability for his left forearm. Former OAR 436-35-110(3)(d).

Dr. Kuller also reported that claimant had sensory loss bilaterally in the thumbs, index, middle and ring fingers. Her report, however, does not provide any means for determining whether claimant's sensory loss has resulted in a rateable impairment. Former OAR 436-35-110(1)(b). Absent specific measurements, we decline to assign a value to claimant's impairment for this factor.

These ratings for loss of grip strength are combined with the 5 percent rating for a chronic condition limiting the use of each forearm, for total awards of 28 percent scheduled permanent disability for the right forearm and 27 percent scheduled permanent disability for the left forearm.

ORDER

The Referee's order dated May 13, 1991 is modified. In lieu of the Referee's increased award of scheduled permanent disability, claimant is awarded benefits for 28 percent (42 degrees) scheduled permanent partial disability for the right forearm and 27 percent (40.5 degrees) for scheduled permanent partial disability for the left forearm. The award is in addition to the prior award of benefits for 26 percent (5.72 degrees) scheduled permanent disability for injury to the right middle finger. Claimant's attorney is awarded a reasonable approved fee of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total amount of attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
TOM D. HUSTED, Claimant
WCB Case No. 91-00950
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Spangler's order that: (1) declined to award additional temporary disability; and (2) declined to assess a penalty and related attorney fee for the SAIF Corporation's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant was compensably injured when his hand was partially amputated on July 5, 1990. He was released to return to modified work by Dr. Nesbit, his treating surgeon, on September 4, 1990.

When claimant returned to work, he was to be employed as a vocational trainer supervising mentally retarded clients on an assembly line. He was not to use his right hand.

The week of November 9, 1990, claimant started to have a "breakdown." He did not return to work after November 12, 1990 because his right hand was swelling and he was having emotional problems related to the mutilation of his hand.

After November 12, 1990 claimant did not call the employer daily to report his absences as required by the employer's personnel policy. However, claimant, his spouse and his mother reported his absence three times between November 12 and November 26, 1990. Additionally, claimant called one other time after November 26, 1990 to report that he was going to the doctor and would not be reporting to work.

On November 26, 1990, Dr. Nesbit authorized additional time loss until December 3, 1990 to allow claimant to be fitted with a protective work glove for his right hand. Also on that date, the employer sent claimant a warning letter stating that, effective December 3, 1990, claimant would be terminated if he failed to report his absences daily. Claimant was fitted for his protective work glove on or about November 30, 1990.

In December 1990, claimant had thoughts of suicide and a possible suicide attempt. On December 7, 1990, the employer concluded that claimant had abandoned his job and terminated claimant due to his unexplained absences. Thereafter, claimant's total temporary disability was stopped.

Dr. Mead, claimant's treating psychiatrist, evaluated claimant on January 3, 1991 and diagnosed adjustment disorder (depressive) resulting from claimant's compensable injury. Mead concluded that claimant's inability to work was caused by depression resulting from the trauma of his injury and his association of that trauma with the workplace. On February 19, 1991, SAIF authorized limited psychiatric treatment for claimant's psychiatric condition.

In March 1991, claimant underwent further reconstructive surgery. SAIF authorized the surgery and recommenced claimant's temporary disability benefits.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The Referee found that claimant left his modified work for reasons other than his compensable injury. Consequently, the Referee held that claimant was not entitled to temporary total disability (TTD) after he left work in November 1990 and before his March 1991 surgery. On review, claimant argues that he is entitled to TTD during the aforementioned period because he was unable to work as a result of his compensable injury and its residuals. We agree.

Whether a claimant is entitled to TTD benefits depends on whether a preponderance of the evidence indicates that he was disabled during the time due to a compensable injury. Botefur v. City of Creswell, 84 Or App 627 (1987); Kathy K. Mason, 43 Van Natta 1342 (1991). A carrier shall cease paying TTD compensation and start paying temporary partial disability (TPD) from the date an injured worker begins any kind of wage earning employment prior to claim closure. Former OAR 436-60-030(3).

Temporary disability payments are not due if post-injury wages equal or are greater than the at-injury wages. Former OAR 436-60-030(2). TPD compensation shall continue until the attending physician verifies that the worker cannot continue working and is again temporarily totally disabled. Former OAR 436-60-030(4)(a). If a worker is discharged for reasons unrelated to the compensable injury while still temporarily disabled, the worker does not become entitled to the resumption of TTD. Safeway Stores v. Owsley, 91 Or App 475 (1988).

In this case, claimant credibly testified that he did not return to work after November 9, 1990 because he was having a "breakdown." (Tr. 98-98). Dr. Mead, claimant's treating psychiatrist, supports claimant's contention that he was unable to work because of depression, the major cause of which was his injury which he associated with the workplace. (Exs. 20, 20A and 28). Moreover, Dr. Nesbit, claimant's treating surgeon also took claimant off work in order for him to be fitted with a protective work glove.

After our review of the record, we are persuaded that claimant was unable to work during the period in question as a result of his compensable injury and its sequela. Therefore, claimant is entitled to TTD benefits for that period.

Unreasonable Claims Processing

The Referee also concluded that claimant was not entitled to a penalty or related attorney fee for SAIF's allegedly unreasonable refusal to pay benefits during that time period. We agree.

Penalities and attorney fees may be assessed when an insurer "unreasonably delays or refuses to pay compensation." ORS 656.262(10). An insurer does not act unreasonably if it has a legitimate doubt as to its liability. Brown v. Argonaut Co., 93 Or App 588 (1988).

In light of claimant's admitted failure to provide the employer with daily notices of his absence and considering his failure to respond to the employer's "warning" letter, we do not find it unreasonable for SAIF to conclude that claimant had left his job for reasons unrelated to the injury. Under these circumstances, we conclude that SAIF had a legitimate doubt in regard to its continuing liability for TTD benefits. Accordingly, penalties and related attorney

fees are not warranted for SAIF's termination of claimant's temporary disability benefits.

ORDER

The Referee's order dated May 13, 1991 is reversed in part and affirmed in part. That portion which declined to award additional temporary total disability benefits is reversed. Claimant is awarded temporary total disability compensation from November 12, 1990 through the date that SAIF resumed paying claimant benefits in March 1991. SAIF is authorized to offset against this award any temporary disability compensation already paid during that period of time. Claimant's counsel is awarded an approved fee of 25 percent of the increased benefits payable to claimant by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

March 26, 1992 Cite as 44 Van Natta 512 (1992)

In the Matter of the Compensation of
SHARON Y. RODAKOWSKI, Claimant
Own Motion No. 90-0554M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's December 13, 1991 Notice of Closure which closed her claim with an award of temporary disability compensation from February 11, 1991 through December 15, 1991. SAIF declared claimant medically stationary as of December 2, 1991. Claimant contends that she is not medically stationary and is entitled to additional benefits.

An injured worker is medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant initially injured her knee in a fall. In 1987, she underwent arthroscopic debridement of an osteochondral lesion that led to accelerated degenerative changes in the knee. (Letter of December 11, 1990, Dr. Macha). Dr. Singer, claimant's treating physician, stated that claimant was medically stationary in regard to her left knee on December 2, 1991. He recommended that she wear a patellar sleeve to provide stability for her knee and hydrotherapy to maintain flexibility. He noted that claimant might require nonconservative treatment in the future if her knee were to worsen. (Chart note of December 2, 1991). We conclude that, as of December 2, 1991, no further material improvement was reasonably expected from medical treatment or the passage of time.

Claimant nevertheless contends that Dr. Jones, a consulting surgeon, has determined that a total knee replacement should be performed on claimant's left knee as soon as possible. In addition, she contends that she is not medically stationary from an August 1991 right wrist injury which occurred as a consequence of her compensable left knee injury.

We have no medical evidence in the file to support claimant's contention that authorization for a total knee replacement surgery has been requested by the consulting physician. Furthermore, we have no medical evidence that claimant's right wrist injury resulted from claimant's original left knee injury or that SAIF accepted the right wrist injury as a compensable sequela of claimant's 1982 injury.

Claimant's treating physician determined that claimant was medically stationary as of December 2, 1991. Claimant has provided no medical evidence to the contrary. Claimant has the burden of proof on this issue. Therefore, we find that claimant became medically stationary on December 2, 1991 and conclude that SAIF's closure was proper.

Accordingly, SAIF's December 13, 1991 Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOEL O. SANDOVAL, Claimant
WCB Case No. 91-01081
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Baker's order which: (1) found that the insurer improperly terminated payment of temporary total disability compensation; (2) assessed a penalty against the insurer for unreasonable delay or refusal to pay compensation pursuant to ORS 656.262(10); and (3) awarded claimant an attorney fee under ORS 656.382 for unreasonable resistance to the payment of compensation. In its brief, the insurer requests that we admit additional documents into the record which were not admitted at hearing. On review, the issues are remand, entitlement to temporary total disability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact and supplement those findings as follows.

Subsequent to his compensable injury, claimant moved to Los Angeles, California. On October 20, 1990, the insurer wrote the following letter to Dr. Song, claimant's California treating physician: "We have been advised that you are treating [claimant] in regard to his 10-19-89 injury. Please advise us if he has been released for regular work yet. If so, when. We are currently paying timeloss and need a report on his status. When can we expect him to become medically stationary Will he have any permanent impairment? Please advise us." (Ex. 22).

On November 5, 1990, Dr. Song responded as follows:

> "[Claimant] was last seen on 10-23-90 At this time the doctors physical examination sees minimal tenderness on lumbar sacral area, negative tension signs, M/S intact, DTR are within normal limits. Patient is recommended [sic] to obtain a second opinion for further management since he suffers lumbar back pain for over one year. Patient has been released to go back to work on 6-26-90 and returned to us on 7-11-90 for a check up and then on 7-31-90 when he couldn't return to work because of to [sic] much pain so he was put on disability again by Dr. Song. [Claimant] returned on 8-14-90 for a check up then released again on 8-27-90. On 10-23-90 he returned

stating he couldn't work so doctor Haeff M.D. (general practitioner) referred him back to Dr. Song (orthopedic) and at that time is what I mentioned in the above beginning paragraph. At this time Dr. Song would like if you would set up [claimant] with one of your medical doctors to be evaluated [sic] for this condition." (Ex. 23). (Emphasis added).

Pursuant to Dr. Song's request, the insurer sent claimant to Dr. Vandernoot for an independent medical exam (IME). In his report dated December 13, 1990, Dr. Vandernoot opined that claimant was "capable of returning to his usual and customary occupational activities with no work restrictions indicated and was capable of doing so by 11/15/89." (Ex. 24-13).

The insurer terminated claimant's temporary total disability as of December 18, 1990. On January 7, 1991 and March 1, 1991, the insurer wrote to Dr. Song asking him whether he concurred with Dr. Vandernoot's report. By the date of the April 17, 1991 hearing in this matter, Dr. Song had not responded to the insurer's queries. Claimant had left California and moved back to Oregon at the time of the hearing.

CONCLUSIONS OF LAW AND OPINION

Remand

We may remand a case to the Referee for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or App 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). We consider the insurer's request that we admit additional documents into the record as a motion for remand. In this regard, we consider the proffered evidence on review only for purposes of addressing the insurer's remand motion.

The two documents at issue are a communication from Dr. Song concurring with Dr. Vandernoot's report and a Determination Order. The Determination Order has no relevance to the legal question of whether the insurer was entitled to terminate temporary total disability payments. Although Dr. Song's letter is relevant to the question of entitlement to temporary total disability, there has been no showing that this letter was not obtainable with due diligence at the time of the hearing. Accordingly, the motion to remand is denied.

Entitlement to Temporary Total Disability

The Referee concluded that the insurer had improperly terminated temporary total disability compensation because it failed to comply with the requirements of ORS 656.268(3). On review, the insurer argues that it properly terminated temporary total disability because, pursuant to ORS 656.262(4)(b), temporary total disability compensation was not owed for the period of time in question. We agree.

ORS 656.262(4)(b) provides:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to

work, unless the worker has been unable to receive treatment for reasons beyond the worker's control." Or Laws 1990 (Special Session), ch. 2, 15.

Because the legislative intent is evident from the express language of the statute, we need look no further. Whipple v. Howser, 291 Or 475 (1981).[1]

Temporary total disability is not due and payable under ORS 656.262(4)(b) if two requirements are met. First, the insurer must have requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease. Second, the physician must be unable to verify the worker's inability to work. The statute is applicable if these two requirements are met unless the worker has been unable to receive treatment for reasons beyond the worker's control.

At the outset, we note that there is no evidence that claimant was unable to receive treatment for reasons beyond his control. The evidence shows that claimant was being regularly treated by Dr. Song.

We conclude that this letter to Dr. Song is unequivocally a request for verification of claimant's inability to work resulting from the injury. This letter stated, "We have been advised that you are treating [claimant] in regard to his 10-19-89 injury. Please advise us if he has been released for regular work yet. If so, when. We are currently paying timeloss and need a report on his status . . ." (Emphasis added).

We further conclude that Dr. Song was unable to verify claimant's inability to work. In his November 5, 1990 reply to the insurer's request for verification, Song recommended the insurer obtain a second opinion. This letter noted that claimant had been released to work by Dr. Song twice previously. Furthermore, although the letter indicated that claimant had pain complaints, it did not state that claimant's work release had been retracted or that he was unable to work.

On the basis of Dr. Song's recommendation that a second opinion be obtained, claimant was sent to Dr. Vandernoot for an IME. Dr Vandernoot examined claimant and concluded that claimant could return to his regular work without restriction.

Relying on Dr. Vandernoot's December 13, 1990 report, the insurer ceased paying temporary total disability as of December 18, 1990. We do not find the insurer's actions to be unreasonable. It had requested verification from the attending physician. Dr. Song was not able to verify claimant's inability to work and claimant was not unable to receive treatment for reasons beyond his control. The requirements of the statute were met. Temporary total disability compensation was not due and payable from the date of Dr. Song's November 5, 1990 letter.

Based on these facts, we find that, pursuant to ORS 656.262(4)(b), temporary total disability compensation was not due and payable after November 5,

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1 Although we find this statute unambiguous, in Robert E. Riegel, 44 Van Natta 159 (1992), we noted that there is a single, terse statement in the legislative history explaining ORS 656.262(4)(b). In commenting on the proposed legislation, R. Dwinell, a member of the Labor/Management Committee, testified only that "[If] authorization for time loss is not given by the attending physician, time loss is not owed." Joint Committee Proceedings, May 3, 1990, Tape 1, side B at 160.

1990, the date of Dr. Song's response to the insurer's request for verification.

We have found the insurer's conduct to be permitted by the statutes. No penalties or fees are warranted.

ORDER

The Referee's order dated June 12, 1991 is reversed.

March 26, 1992 Cite as 44 Van Natta 516 (1992)

In the Matter of the Compensation of
HAROLD F. SCHULTZ, Claimant
Own Motion No. 92-0009M
OWN MOTION ORDER

The self-insured employer voluntarily reopened the above claim for a worsening of claimant's February 22, 1982 compensable shoulder, neck and low back injury. Claimant's aggravation rights expired on July 22, 1988. The employer requests authorization for reimbursement from the Reopened Claims Reserve.

We may authorize reimbursement from the Reopened Claims Reserve for those benefits which were properly paid pursuant to ORS 656.278. ORS 656.278(1)(a) requires a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization as the predicate to payment of temporary disability compensation. In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

Claimant compensably injured his right shoulder, low back and neck in a fall. He underwent surgery on his neck in 1987 and on his low back in 1988 for conditions related to his original compensable injury. The employer authorized right carpal tunnel surgery on December 3, 1991.

In his November 9, 1991 report of the history of claimant's condition, Dr. Freeman states that subsequent to the fall, claimant had continuous documentation of posterior cervical axis and right arm discomfort, pain, numbness and tingling. Aside from this report, we have no further medical information about claimant's right arm condition until, in 1988, when Dr. Freeman diagnosed carpal tunnel syndrome on the right. In 1991, he found bilateral carpal tunnel symptoms, right greater than left. (Letter of November 9, 1991). In 1991, Dr. Patterson, neurologist, reported that five or six years earlier when driving a truck, claimant noted the onset of numbness and tingling of his hands and arms, worse on the right than the left. In 1991, he diagnosed bilateral carpal tunnel syndrome. (Letter of November 21, 1991). Dr. Patterson opines that surgery is justified for claimant's current bilateral carpal tunnel syndrome. Thus, we find that surgery is required for claimant's current condition.

However, the above contradictory histories of the onset of claimant's bilateral carpal tunnel condition are insufficient to establish that his right carpal tunnel condition is the result of his compensable injury to his shoulder, neck and low back. Consequently, claimant has not established that his current condition is a worsening of his compensable injury.

According, we deny the employers request for authorization for reimbursement from the reopened claims reserve.

IT IS SO ORDERED.

In the Matter of the Compensation of
DARRELL D. TUTTLE, Claimant
Own Motion No. 91-0018M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Hollander & Lebenbaum, Claimant Attorneys

Claimant requests review of the carrier's November 11, 1991 Notice of Closure which closed his claim with an award of temporary disability compensation from March 11, 1991 through November 1, 1991. The carrier declared claimant medically stationary as of November 1, 1991. Claimant contends that he is entitled to additional benefits.

Medically stationary means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant's 1980 (left wrist) and 1984 (right wrist) claims were reopened for the payment of temporary total disability compensation related to bilateral wrist surgeries. Dr. Layman performed a right wrist surgery on January 18, 1991 and a left wrist surgery on March 11, 1991. Claimant requests review of the closure of his 1980 (left wrist) claim only. Dr. Layman opined that claimant was medically stationary as to both wrists on November 1, 1991. He noted that claimant had decreased grip strength on the left, but evaluated this as a permanent impairment. Evaluation of permanent impairment implies that no material improvement would reasonably be expected with further treatment or the passage of time. Claimant, who has the burden of proof on this issue, has not submitted any medical evidence to the contrary. Therefore, we find that claimant was medically stationary on November 1, 1991.

Accordingly, the carrier's November 11, 1991 Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
SAM L. HOOVER, Claimant
WCB Case No. 90-06155
ORDER DENYING RECONSIDERATION
Gatti, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Claimant requests reconsideration of our March 16, 1992 Order on Remand that awarded claimant a $750 insurer-paid attorney fee under ORS 656.386(1) for services rendered in prompting the rescission of the SAIF Corporation's denial prior to the scheduled hearing. Relying on services expended subsequent to SAIF's April 16, 1990 rescission or devoted to the "unreasonable denial" issue, claimant contends that his attorney fee award concerning the rescinded denial issue "should be doubled at a minimum."

As stated in our prior order, we considered the factors set forth in OAR 438-15-010(4) in determining the amount of a reasonable assessed fee concerning SAIF's April 16, 1990 rescission of its March 12, 1990 denial prior to the scheduled June 25, 1990 hearing. In determining that a reasonable fee for such services was $750, we expressly noted that claimant's attorney had already received a $800 fee for an unreasonable denial. Finally, since services rendered subsequent to SAIF's rescission would not be devoted to prompting the rescission, we further concluded that such services would not be considered.

After considering claimant's motion, we have nothing further to add to our prior order. Accordingly, the motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our March 16, 1992 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN DAVISON, Claimant
WCB Case No. 90-22456
ORDER ON REVIEW
Meyers & Radler, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Schultz's order that limited the assessed penalty against the SAIF Corporation for failure to timely pay medical bills to 25 percent of all unpaid medical expenses submitted more than 60 days before the date of the hearing request. On review, the issues are penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Penalties on Failure to Timely Pay Medical Bills / "De Facto" Denial

Relying on claimant's assertions at hearing, the Referee applied the Director's rules dealing with untimely payment of medical bills. On that basis, he assessed a penalty of 25 percent of unpaid medical bills submitted more than 60 days before October 15, 1990, the date of claimant's hearing request. The Referee also determined that SAIF's conduct was unreasonable in failing to accept or deny the claim within 90 days of notice or knowledge of the claim. Because the Referee determined that the maximum penalty had been assessed on these same amounts for SAIF's failure to timely pay the medical bills, he assessed a $250 attorney fee pursuant to ORS 656.382 for this "de facto" denial.

We disagree that this case involves untimely payment of medical bills. Instead, we find that the "de facto" denial is the actual basis for the assessment of penalties due to SAIF's inaction.

Rather than untimely paying the medical bills, SAIF made no payment of the bills. Claimant's son submitted the bills on a monthly basis and SAIF simply ignored them. By failing to respond in any fashion, SAIF in effect "de facto" denied the claim. No formal denial was ever issued, and it was not until the February 5, 1991 hearing that SAIF's attorney orally denied the claim. Thus, this "de facto" denial is the actual basis for the assessment of penalties due to SAIF's total failure to process this claim. See Marvin D. Cornett, 43 Van Natta 1270 (1991); Delbert King, 43 Van Natta 1047 (1991).

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). 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).

We have held that the penalty basis for an untimely denial includes that compensation which was due but unpaid during the delay period. Jeffrey D. Dennis, 43 Van Natta 857 (1991). Thus, the delay period runs from the 91st day after notice of the medical services claim until the date of the denial. ORS 656.262(6); Jeffrey D. Dennis, supra; Delbert King, supra; Marvin D. Cornett, supra; Clinton F. Seals, 42 Van Natta 268 (1990).

Here, SAIF was notified of the claim for nursing home services on June 20, 1990. (Ex. 13). This claim was not denied until hearing. Therefore, the 25 percent penalty should be based on the amounts due between the 91st day after June 20, 1990, the date of notice of the claim, and February 5, 1991, the date of the hearing. Because the "de facto" denial is the only basis for a penalty due to SAIF's inaction, the above penalty is assessed in lieu of the penalties and attorney fee assessed by the Referee for "untimely payment" and "de facto" denial. One-half of this penalty shall be paid to claimant's attorney in lieu of an attorney fee. ORS 656.262(10).

The Referee's $250 attorney fee award is reversed. See Nicolasa Martinez, 43 Van Natta 1638 (1991). In reaching this conclusion, we note that claimant states that he is not contesting the Referee's decision on this issue. Nevertheless, on de novo review we are authorized to make such disposition of the case as we determine to be appropriate. ORS 656.295(6): Destael v. Nicolai Co., 80 Or App 596 (1986). Inasmuch as the Referee's $250 attorney fee award under ORS 656.382(1) is contrary to the Martinez holding, we have exercised our authority to correct the Referee's erroneous award.

Penalty Based on Medical Aide Stipend

The Referee also awarded claimant and his attorney a penalty pursuant to ORS 656.262(10)(a) in the amount of 15 percent of the $571 monthly medical aide stipend "which should have been paid to [claimant's wife] between June 10, 1990 and February 5, 1991, less amounts previously paid."

SAIF argues, and claimant concedes, that the Referee did not order it to continue payment of the medical aide stipend to Mrs. Davison after June 10, 1990. Furthermore, SAIF argues that no stipend "should have been paid" after June 10, 1990 because Mrs. Davison provided no services for claimant after that date since claimant was either in the hospital or a nursing home after that date. Finally, SAIF argues that any penalty based on Mrs. Davison's previous medical aide stipend would constitute a double penalty because the Referee also assessed a penalty of 25 percent of the unpaid medical services which included nursing home bills.

We agree with SAIF's arguments. While claimant was living at home, Mrs. Davison was paid a monthly stipend for the many services she provided him. After June 10, 1990, claimant no longer lived at home, and Mrs. Davison provided no further medical aide services for him. Thus, there are no medical aide services upon which to calculate this penalty.

Furthermore, as discussed above, a 25 percent penalty has been assessed on all unpaid medical bills, which include nursing home bills, as of the date of the hearing. There is no legal authority to assess penalties totalling more than 25 percent of the compensation then due. ORS 656.262(10); Mollie E. Barrow, 43 Van Natta 617 (1991); Kim L. Haragan, 42 Van Natta 311 (1990).

Accordingly, we reverse that portion of the Referee's order that assessed a penalty based on the medical aide stipend.

ORDER

The Referee's order dated April 4, 1991, as corrected April 8, 1991, is modified in part, reversed in part, and affirmed in part. The penalty based on medical aide stipend is reversed. In lieu of the assessed attorney fee of $250 and the penalty of 25 percent of all unpaid medical expenses submitted more than 60 days before October 15, 1990, claimant is awarded a penalty of 25 percent of the amounts due between the 91st day after June 20, 1990, the date that the SAIF Corporation had notice of the claim, and the February 5, 1991 hearing. One-half of this penalty shall be paid to claimant's attorney in lieu of an attorney fee. The remainder of the order is affirmed.

March 30, 1992 Cite as 44 Van Natta 520 (1992)

In the Matter of the Compensation of
JIMMIE L. MARTIN, Claimant
WCB Case No. 91-04769
ORDER ON REVIEW
Max Rae, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Myzak's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) assessed a penalty for an unreasonable denial of the aggravation claim. On review, the issues are aggravation and penalties.

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

The insurer does not dispute the Referee's finding, on the merits, that claimant has established a compensable aggravation claim. Instead, the insurer argues on review, as it did at hearing, that claimant's aggravation claim was not timely filed. The insurer bases this argument on the fact that claimant's attorney's February 26, 1991 letter, which requested that claimant's claim be reopened due to a worsening of his condition, did not include a physician's report that would satisfy the requirements of ORS 656.273(3).

However, a physician's report is not the only mechanism for making an aggravation claim. Claimant may make a claim for an aggravation under ORS 656.273(2) or, alternatively, a physician may submit a report which is a claim for an aggravation under ORS 656.273(3). Stevens v. Champion International, 44 Or App 587 (1980); Richard J. Stevenson, 43 Van Natta 1883 (1991); Herman M. Carlson, 43 Van Natta 963, 964 n.1 (1991).

Claimant's attorney's letter was delivered by certified mail to the insurer on February 28, 1991, the last day of the five year period in which claimant could make an aggravation claim. (Ex. 27A-2). Therefore, we agree with the Referee's determination that claimant timely made an aggravation claim on February 28, 1991.

In reaching this conclusion, we note that the letter from claimant's attorney served only to preserve claimant's right to seek additional compensation for an aggravation. The letter did not, however, entitle claimant to interim

compensation or any other benefits. To obtain interim compensation, claimant had to submit a medical report which was sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition had worsened from a medical standpoint as a result of which, he was unable to work. Doris A. Pace, 43 Van Natta 2526 (1991); Richard J. Stevenson, supra. Here, such medical reports were ultimately provided, since the insurer does not even dispute the Referee's finding that claimant established a compensable aggravation on the merits.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. 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 attorney's services on review concerning the aggravation issue is $700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services on review concerning the penalty issue. Saxton v. SAIF, 80 OR App 631 (1986)

ORDER

The Referee's order dated July 25, 1991 is affirmed. For services on review regarding the aggravation issue, claimant's attorney is awarded an assessed fee of $700, to be paid by the insurer.

In the Matter of the Compensation of
ESTHER C. ALBERTSON, Claimant
WCB Case No. 91-00565
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The insurer requests review of Referee Peterson's order that: (1) set aside its denial of temporary total disability benefits for the period commencing September 24, 1990; (2) assessed a penalty for an allegedly unreasonable denial; and (3) awarded an insurer-paid attorney fee concerning the temporary disability issue. On review, the issues are temporary total disability, penalties, and attorney fees.

We affirm and adopt the order of the Referee regarding the temporary total disability issue, with the following exception and supplementation. We modify with respect to the penalty and attorney fee issue.

In deciding this matter, the Referee applied the law in effect prior to the July 1990 amendments. See Or Laws 1990 (Special Session), ch. 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation savings clause contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See, e.g., section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Law as amended, effective July 1, 1990.

Temporary Total Disability

The Referee cited Jackson v. SAIF, 7 Or App 109 (1971), in support of his conclusion that the insurer is not permitted to terminate temporary disability compensation where the claimant is not medically stationary, is receiving treatment, is not released to work and has not returned to regular work. However, Jackson v. SAIF, supra, interpreted a former version of ORS 656.268(3) concerning an insurer's authority to unilaterally terminate payment of such compensation. Although we reach the same result, we do not rely on Jackson, supra, because the law has changed.

Current ORS 656.268(3) provides that an insurer may unilaterally terminate payment of temporary total disability compensation only if:

> "a) The worker returns to regular or modified employment;
>
> "b) The attending physician gives the worker a written release to return to regular employment; or
>
> "c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

See Rocky L. Coble, 43 Van Natta 1907 (1991). Here, none of these circumstances had occurred, and the insurer was, therefore, without authority to unilaterally terminate claimant's temporary total disability benefits.

The insurer argues that claimant is not entitled to temporary disability benefits for the period commencing September 24, 1990, based on its contention that she had withdrawn from the work force when she became a full-time student on that date. We disagree for the following reasons.

First, the courts have held that "the critical time for determining whether a claimant has withdrawn from the work force is at the time of his disability." Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); see Dawkins v. Pacific Motor Trucking, 308 Or 254, 257 (1989). "Our inquiry focuses on whether claimant had withdrawn from the work force at the time of the aggravation of his prior work-related injury." Kepford, supra at 413 n.1. In Kepford, the court further held:

> "[C]laimant was working and was, therefore, a member of the work force when he became disabled by his occupational disease. It matters not that he retired or had withdrawn from the work force after that time. Under Dawkins, he need not show that he remained in the work force."

100 Or App at 415.

Nothing in the 1990 amendments to the Workers' Compensation Law affects the reasoning, holdings or applicability of the Dawkins and Kepford cases to the present issue regarding this claimant's continuing entitlement to pre-closure temporary total disability (TTD) compensation. Because claimant was in the work force on September 4, 1990 (the date of disability associated with her aggravation), the insurer was not entitled to unilaterally terminate her TTD compensation thereafter, in the absence of one of the events described in ORS 656.268(3). See Rocky Coble, supra.

In support of its unilateral termination of temporary disability benefits, the insurer relied on former OAR 436-30-036 (Temp. rule, effective July 1, 1990), which provides in relevant part:

"(3) A worker is not entitled to any award for temporary disability for any period of time in which:

"* * * *

"(f) The worker has withdrawn from the work force;

"* * * *

"(9) For the purpose of determining the applicability of section (3)(f), a worker has withdrawn from the work force when:

"* * * *

"(d) A worker has elected to return to school or college on a full or part time basis, unless the worker can establish a prior customary practice of working while attending school or college."

This rule is part of Division 30 of OAR chapter 436, which deals with claim closure and a claimant's substantive right to temporary disability benefits, which are "awarded" in a Determination Order or Notice of Closure. The purpose of Division 30 is to describe the functions of the Evaluation Section and prescribe the claim closure process. OAR 436-30-002. OAR 436-30-036(3) and (9) are not authority for, and have no applicability to, determining the insurer's procedural obligation, which is to pay temporary disability benefits until claim closure, unless one of the events enumerated in ORS 656.268(3) occurs.

The administrative rules relating to claims processing, and the rules which set forth the circumstances under which temporary disability benefits may be unilaterally terminated, are set forth in OAR 436, Division 60. There is nothing in that division which provides support for the insurer's unilateral termination of benefits in this case. We conclude, therefore, that the insurer acted without authority in unilaterally terminating claimant's benefits.

Penalty

We agree with the Referee's conclusion that the insurer's action was unreasonable. The attempted application of Division 30 claim closure rules to an open claim, the circumvention of the express language of the statute, and the failure to abide by the claims administration rules of Division 60 by an experienced insurer constituted an unreasonable refusal to pay compensation. See ORS 656.262(10)(a).

On review, both parties appear to allege that the Referee assessed an attorney fee of $1,250 based on the insurer's unreasonable conduct. However, based on our review of the Referee's order and the record, including claimant's counsel's statement of services at hearing, we find that the Referee assessed the $1,250 fee for prevailing over the insurer's denial of temporary disability benefits, not for the insurer's unreasonable conduct. The Referee did not assess an attorney fee under ORS 656.382(1).

Claimant's counsel is entitled to one-half of the penalty awarded claimant in lieu of a penalty-related attorney fee. See ORS 656.262(10)(a); Nicolasa Martinez, 43 Van Natta 1638 (1991). As the Referee omitted this provision, we include it here.

Attorney Fees

Although neither party raised this issue, we find that the Referee erred in assessing the $1,250 insurer-paid attorney fee for prevailing on the temporary disability issue. Because the insurer's denial only concerned the amount of temporary disability benefits to be paid on a previously accepted claim for a

left hand condition, claimant is not entitled to an assessed attorney fee under ORS 656.386(1). James R. Jones, 42 Van Natta 238 (1990; see also Charles L. Smith, 41 Van Natta 75 (1989). Rather, the attorney fee is payable out of the increased compensation. See ORS 656.386(2); OAR 438-15-045. Accordingly, we approve an attorney fee of 25 percent of the increased temporary disability compensation awarded by the Referee, not to exceed $1,050.

Claimant's counsel is entitled to an assessed attorney fee for prevailing against the insurer's request for review. See 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 assessed attorney fee for claimant's counsel's services on review concerning the temporary total disability issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services pertaining to the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated April 16, 1991 is modified in part and affirmed in part. One-half of the penalty awarded to claimant shall be paid to claimant's counsel, in lieu of an attorney fee. In lieu of the Referee's award of an insurer-paid attorney fee of $1,250, we approve an out-of-compensation attorney fee of 25 percent of the increased temporary disability compensation awarded by the Referee, not to exceed $1,050. The remainder of the order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $500 for his services on review, payable by the insurer.

In the Matter of the Compensation of
ADAM J. DELFEL, Claimant
WCB Case No. 91-01987
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Nelson, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Schultz's order that: (1) directed the insurer to calculate claimant's rate of temporary disability benefits based on his average weekly earnings for a 16 week period without including those weeks when claimant had no earnings; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable rate of temporary disability. The insurer cross-requests review of that portion of the order regarding the rate of temporary disability. On review, the issues are rate of temporary disability and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact but correct the date of injury in the first paragraph from January 10, 1991 to January 20, 1991.

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Disability

Claimant first asserts that, as of December 31, 1990, he should be considered a "regular employee." We agree with the Referee that claimant was not "regularly employed" under ORS 656.210(2)(c). Both claimant and his supervisor testified that claimant was "part-time" and worked according to the needs of the employer. (Tr. 13-14, and 17). The Referee therefore correctly analyzed the proper rate of temporary disability under former OAR 436-60-025(4)(a). See Overbey v. Kaiser Health Plan, 93 Or App 175, 180 (1988) (claimant's employment held to be "irregular" when the parties intended that claimant's working hours would vary according to her availability and the employer's needs).

Former OAR 436-60-025(4)(a) provides:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker."

The Referee concluded that claimant did not fall under the first two sentences of the rule, finding that the seven-week period when claimant did not work from November 8 through December 30, 1990 constituted an "extended gap" and that claimant did not work four weeks of employment prior to the date of injury.

Determining what is an "extended gap" is not based solely on the length of the break in work, but must also be based on whether the gap has caused a change in the work relationship between employer and employee. Craig E. Hobbs, 39 Van Natta 690 (1987). Whether extended gaps in a claimant's employment exist should be determined on a case-by-case basis. Dena L. Barnett, 43 Van Natta 1776 (1991); Sally M. Turpin, 37 Van Natta 924, 926 (1985). For instance, if the work is seasonal, periods of layoff generally are to be expected; consequently, unless abnormally lengthy or occurring during an irregular time of year, periods of layoff are not considered "extended gaps." Sally M. Turpin, supra.

Here, there was testimony that the employer's work was seasonal, with slow periods in June through July and November through December. (Tr. 19). Claimant was told in early November that there would be little work and he was advised to apply for unemployment benefits; claimant also was told that work would be available at the first of the year. (Tr. 10). Throughout claimant's employment with the employer, he was on-call and worked according to the needs of the employer at the same wages. (Tr. 21-22).

In light of this testimony, we find that the breaks in employment, including the seven-week period, do not constitute "extended gaps" under former OAR 436-60-025(4)(a). The breaks in employment were within the reasonable expectations of claimant and the employer, in that a long layoff could be expected in November and December, as well as short layoffs at other times of the year. Furthermore, claimant's relationship with the employer did not alter as a result of the break. We therefore conclude that the rate of temporary disability should be based on claimant's average weekly earnings during his 25 weeks of employment with the employer.

Moreover, we agree with the insurer that claimant's overtime earnings should be included in claimant's temporary disability. Former OAR 436-60-025(2)(g) provides in part:

"Insurers shall consider overtime hours only when the worker worked overtime on a regular basis. Overtime earnings shall be included in the computation at the overtime rate. * * * If overtime varies in hours worked per day or week, use the averaging method described in subsection (a). * * *"

A claimant works overtime "on a regular basis" if the worker frequently works overtime, as opposed to overtime that is sporadic. Guy M. Gabel, 42 Van Natta 2314, 2316 (1990). Here, claimant was paid for overtime or double time on more than half of the days that he worked. (Ex. A). We therefore conclude that claimant's overtime was frequent and not sporadic, bringing him under former OAR 436-60-025(2)(g). In determining the rate of temporary disability, the rule provides that we use the averaging method contained in subsection (a). Consequently, claimant's overtime hours worked over the 25 week period will be averaged into the rate of temporary disability.

In conclusion, the Referee calculated the rate of temporary disability by averaging claimant's earnings without considering those weeks when claimant did not work. We modify the order to provide that the rate of temporary disability is to be calculated according to claimant's average weekly earnings for the previous 25 weeks before the date of injury, such rate to include regular, overtime and double time hours.

Penalties and Attorney Fees

We adopt that portion of the Referee's order declining to award claimant a penalty under ORS 656.262(10)(a) or attorney fee under ORS 656.382(1). Moreover, we note that, even if claimant was entitled to a penalty under ORS 656.262(10)(a), claimant's attorney would receive one-half of the amount "in lieu of an attorney fee," and therefore would not be entitled to an attorney fee under ORS 656.382(1). Nicolasa Martinez, 43 Van Natta 1638 (1991).

ORDER

The Referee's order dated May 24, 1991 is modified in part and affirmed in part. That portion of the order finding that the rate of temporary disability should be calculated by averaging claimant's actual earnings for weeks worked is modified. The rate of temporary disability will be based on claimant's average weekly earnings for the 25 weeks prior to the date of injury, including regular, overtime and double time earnings. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, payable directly to claimant's counsel. However, the total out-of-compensation attorney fee payable from this order and the Referee's order shall not exceed $3,800. The remainder of the order is affirmed.

In the Matter of the Compensation of
CELESTE S. DEMETER, Claimant
WCB Case No. 91-02990
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Wallace & Klor, Defense Attorneys

The self-insured employer requests reconsideration of our March 5, 1992 Order on Review which affirmed the Referee's order that set aside the employer's denial of psychological treatment. The employer argues that our analysis of the compensability of the treatment is inconsistent with the compensability analysis applied in Judy R. Hicks, 44 Van Natta 204 (1992). We disagree.

In Hicks, the claimant sustained various injuries in a motor vehicle accident (MVA) while returning home from physical therapy for the continuing effects of a compensable injury. The insurer denied the compensability of those injuries. The Board upheld the denial, concluding that the compensable injury was not the major contributing cause of the MVA injuries.

In this case, claimant developed a psychological disorder as a result of inappropriate sexual remarks made by her chiropractor during treatment for the continuing effects of a compensable back injury. The employer denied the compensability of the disorder. We set aside that denial, concluding that the compensable injury was the major contributing cause of the disorder.

The analysis applied in this case is the same as in Hicks. Both cases applied the "major contributing cause" standard set forth in ORS 656.005(7)(a)(A). Although the record in Hicks was not sufficient to meet that standard of causation, the record in this case was sufficient.

Accordingly, we withdraw our March 5, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our March 5, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOUISE A. GREINER, Claimant
WCB Case No. 91-01997
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Edward C. Olson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of Referee Galton's order that: (1) found that the Hearings Division had jurisdiction over a dispute concerning the enforcement of a Stipulated Order; (2) set aside a "de facto" denial of chiropractic treatment; and (3) assessed a penalty and attorney fee for unreasonable claims processing. On review, the issues are jurisdiction, medical services and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that the Stipulated Order was a final judgment and res judicata barred the employer from relitigating the issue. The Referee also concluded that application of the 1990 amendments to the Workers' Compensation Act to a contract previously entered into by the parties would result in an unconstitutional interference with a contractual obligation. Finally, the Referee concluded that the medical services issue was a question concerning a claim, over which the Hearings Division had jurisdiction. We agree that the Hearings Division has jurisdiction over this matter; however, we apply the following analysis.

Pursuant to ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. In the present case, the employer essentially argues that the issue in this case consists of a medical services dispute, which does not involve a matter concerning a claim.

ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." Thus, the employer argues that, in effect, the Director, rather than the Hearings Division, has original jurisdiction in this case. We disagree.

The employer argues solely that the chiropractic care provided by Dr. Nichols is not compensable despite the terms of the Stipulated Order, as the 1990 amendments in Oregon Laws 1990 (Special Session), chapter 2, have removed issues of palliative care from the jurisdiction of the Hearings Division. Accordingly, we conclude that the issue here concerns the appropriate application of a stipulated order, i.e., an enforcement dispute. The Board, and thus the Hearings Division, has jurisdiction to enforce settlement stipulations. See, e.g., Kevin A. Haines, 43 Van Natta 1041 (1991).

In Haines, the stipulation authorized the insurer to discontinue vocational services when appropriate under "the rules governing vocational assistance." Because the dispute concerned the appropriate application of the Director's administrative rules, we found that the claimant could not invoke the jurisdiction of the Hearings Division before seeking administrative review by the Director, notwithstanding the fact that the Board generally has jurisdiction to enforce stipulated settlements. Haines, supra.

In the present case, the stipulated order provides that "claimant shall be entitled to receive palliative care not to exceed two treatments per month without adequate justification of treatments in excess of the guidelines provided." Although the stipulation here makes reference to an administrative rule (i.e., the administrative rules providing for chiropractic care in excess of the guidelines), we reiterate that the employer has not challenged claimant's treatments on that basis. Rather, the employer defends its failure to comply with the terms of the stipulation on the ground that the new law first requires authorization for palliative care from the Director. Accordingly, we find this case distinguishable from Haines.

Finally, we conclude that the present case is more analogous to the facts presented in Patrick E. Riley, 44 Van Natta 281 (1992). In Riley, the stipulated order made no reference to any statute or administrative rule. Rather, we found that the dispute solely concerned the meaning and application of the terms of the stipulation. Riley, supra. Accordingly, we concluded that the Hearings Division had jurisdiction to enforce the stipulation.

We acknowledge that the stipulation in the instant case includes a reference to the guidelines. However, as we have found above, the dispute in this case solely concerns the application of the terms of the stipulation. Under the circumstances, we conclude that there is no procedure available in Chapter 656 for resolving this dispute. We, therefore, agree with the Referee that the Hearings Division has jurisdiction over the question of enforcement of the stipulated settlement.

Medical Services

We agree with and adopt the portion of the Referee's order that directed

the employer to comply with the terms of the stipulation. The employer's "de facto" denials of claimant's chiropractic care are, therefore, set aside.

Penalties and Attorney Fees

We adopt that portion of the Referee's order that assessed a penalty and attorney fee.

Claimant's counsel is entitled to an assessed attorney fee for prevailing against the employer's request for review. See 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 issues of jurisdiction and medical services is $800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief) and the value of the interest involved.

ORDER

The Referee's order dated May 28, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, payable by the self-insured employer.

March 31, 1992 Cite as 44 Van Natta 529 (1992)

In the Matter of the Compensation of
MICHAEL W. HARDENBROOK, Claimant
WCB Case No. 90-18961
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig, Tenenbaum and Moller.

The insurer requests review of Referee Leahy's order that set aside its denial of claimant's claim for a right knee injury. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact," as supplemented, except for the last paragraph.

Claimant played basketball on his paid breaks and unpaid lunch break for his personal pleasure.

The hearing was held on January 30, 1991.

FINDINGS OF ULTIMATE FACT

Claimant's injury was incurred while he was engaged in activities primarily for his personal pleasure.

Claimant's injury did not occur in the course of his employment.

CONCLUSIONS OF LAW AND OPINION

In deciding this mater, the Referee apparently applied workers' compensation law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue is not subject to a special exception to the Act's general applicability provision. See, e.g., section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Finding the insured initiated basketball activity for its benefit in having a productive workforce, the Referee concluded that claimant's right knee injury is compensable. On review, the insurer argues that ORS 656.005(7)(b)(B) requires that a statutory exclusion analysis precede any unitary work connection analysis. See Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). We agree. See Charles E. Negus, 42 Van Natta 2399 (1990)(construing former ORS 656.005(7)(a)(B), now amended ORS 656.005(7)(b)(B)).

ORS 656.005(7) defines a "compensable injury" as an accidental injury arising out of and in the course of employment; it does not include, however, any injury incurred while engaging in recreational activity primarily for the worker's personal pleasure. Subsection (b)(B) of ORS 656.005(7), Or Laws 1990 (Special Session), chapter 2, section 3. The statute excludes, inter alia, certain recreational activities from the definition of compensable injury. However, the statute does not automatically exclude those recreational activities that have a close work nexus and are not performed "primarily" for the worker's personal pleasure.

As claimant's injury occurred while he was playing basketball on the employer's premises during his unpaid lunch break, our initial inquiry in determining whether claimant's injury arose out of and in the course of employment must, therefore, concern why claimant was playing basketball. It is uncontroverted that the employer initiated an opportunity for the basketball games on breaks and lunch periods in part to increase productivity and raise employee morale, and that it provided the backboard and ball and decided where to place the hoop. Claimant's supervisor participated in these games, sometimes encouraging other employees to play. However, he did so as "just another player," rather than in a supervisory capacity. We believe the benefit to the employer, improved morale and energy, was incidental, and was given too much weight by the Referee, when viewed along with the other circumstances of the case.

Claimant testified that he was not required to play basketball as part of his job. He played on his paid breaks and unpaid lunch periods because playing basketball is fun and he loves to play. In addition, he stated that it was an enjoyable way to relieve the stress and tension of work, and break up the monotony of the day. On these facts, we find this recreational activity did not have a close work nexus and was performed "primarily" for the worker's personal pleasure.

Moreover, although no one Mellis factor is dispositive, if we analyze claimant's injury under the unitary work connection test, we are persuaded that there was not a sufficient benefit to the employer to find a work connection between an injury occurring during this lunch-time basketball game and claimant's employment. See Richmond v. SAIF, 58 Or App 354 (1982); Steven M. Chambers, 42

Van Natta 2600 (1990)(benefit must be beyond an improvement in employee health or morale in order to constitute benefit to the employer).

In summary, we find that claimant's right knee injury was incurred while he was engaging in activities primarily for his personal pleasure. This is the type of injury the legislature intended to exclude from the 1990 statutory definition of "compensable injury" when it modified subsection (b)(B) of ORS 656.005(7). As claimant's knee condition did not arise out of and in the course of his employment, it is not compensable.

ORDER

The Referee's order dated February 25, 1991 is reversed. The Referee's award of an assessed attorney fee is reversed. The insurer's September 18, 1990 denial is reinstated and upheld.

Board Member Moller dissenting.

I concur with the majority's conclusion that amended ORS 656.005(7)(b)(B) requires that a statutory exclusion analysis precede any unitary work connection analysis in determining compensability of injuries incurred while participating in recreational activities. However, on the facts of this case, I would find the claim compensable.

Here, playing basketball on paid breaks and unpaid lunch periods was not merely a recreational activity; it also had a significant work nexus. The employer initiated, financed, and constructed a basketball court on its premises; provided a ball; and at least subtly encouraged workers to play. It did this solely to raise employee morale and thus increase productivity. Claimant played to release tension and stress, and to break up the monotony of the day; he has never denied that he found playing basketball to be a fun activity. Under these circumstances, playing basketball had a close work nexus and was not performed "primarily" for the worker's personal pleasure. Accordingly, I would conclude that this "recreational activity" does not fit into the 1990 statutory exclusion to the definition of "compensable injury."

Having found no statutory bar to compensability, I would then concur with the Referee's work-relatedness assessment and find claimant's injury compensable under the unitary work connection test. Although no one Mellis factor is dispositive, when taken as a whole, I am persuaded that there is a significant work connection between the lunch-time basketball game and claimant's employment.

The majority dismisses any benefit to the employer, which it characterizes as improved morale and energy, as merely an "incidental" benefit. However, as the Referee correctly concluded, the employer initiated this activity for "the employer's benefit in having an emotionally healthy group of workers to return to his machines for a productive afternoon." [emphasis supplied]. Having a productive workforce constitutes more than an "incidental" benefit to an employer. Consequently, I would affirm the Referee's conclusion that claimant's knee injury arose out of and in the course of his employment and is, therefore, compensable.

Therefore, I respectfully dissent.

In the Matter of the Compensation of
VINCENT L. KEPHART, Claimant
WCB Case Nos. 90-15053 & 90-15054
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee McWilliams' order that: (1) upheld the SAIF Corporation's denial of claimant's June 1990 right shoulder injury claim; and (2) granted Liberty Northwest Insurance Corporation's motion to dismiss claimant's Request for Hearing on the basis that he was not a subject worker of its insured. On review, the issues are compensability of claimant's consequential condition and subjectivity.

We affirm and adopt the Referee's order, with the following comments. Concerning SAIF's denial, under ORS 656.005(7)(a)(A), a worker who suffers a second injury as a consequence of the original compensable injury will be compensated for the second condition only if the compensable injury is the major contributing cause of that injury. See Julie K. Gasperino, 43 Van Natta 1151 (1991). Claimant has not sustained his burden of proof under ORS 656.005(7)(a)(A).

Concerning the subject worker issue, remuneration, or "wages," is defined as "the money rate at which the service rendered is recompensed . . . or similar advantage received from the employer. . . ." ORS 656.005(27). We do not find that the "practical experience" claimant gained during two weeks of observation and supervised driving constitutes an "advantage" that "rises to the level of remuneration." See, e.g., Robert A. Olson, 43 Van Natta 1431 (1991)(accrued flight time not considered a form of remuneration in calculating rate of temporary disability benefits). Therefore, we agree that claimant was not a subject worker of Liberty Northwest's insured. See BBC Brown Boveri v. Lusk, 108 Or App 623, 626-27 (1991).

ORDER

The Referee's order dated January 14, 1991 is affirmed.

In the Matter of the Compensation of
JAMES J. KITCHIN, Claimant
WCB Case No. 90-21594
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Tenenbaum's order that found that the Hearings Division was without jurisdiction to review the director's dismissal of claimant's request for review of the SAIF Corporation's termination of vocational assistance. On review, the issue is jurisdiction. We conclude that we have jurisdiction and we affirm the Order of Dismissal.

FINDINGS OF FACT

We adopt the Referee's findings of fact regarding the vocational assistance issue.

CONCLUSIONS OF LAW AND OPINION

ORS 656.283(2) places initial jurisdiction concerning vocational assistance with the Director. Consequently, a claimant must first apply to the Director for review regarding such issues; the Hearings Division then has jurisdiction to review the decision of the Director. See e.g. David M. Marvin, 42 Van Natta 1778, 1780 (1990). In this case, claimant did apply for review by the Director. Although the Director dismissed the application because it was not timely filed, the fact that claimant applied for review by the Director, and the Director (through the Rehabilitation Review Section) made a decision regarding the application, satisfies ORS 656.283(2). We therefore conclude that we have jurisdiction to review the Director's dismissal.

ORS 656.283(2) requires that a worker who is dissatisfied with an action of the insurer regarding vocational assistance first apply for review to the Director "not later than the 60th day after the date the worker was notified of the action." Here, it is undisputed that claimant received an end of eligibility letter from SAIF on April 21, 1990 but did not apply for review until November 9, 1990. Therefore, claimant did not timely apply for review as required by the statute. We are unable to conclude that the Director's order falls within one of the circumstances listed in ORS 656.283(2)(a) through (d). Accordingly, we are without authority to modify that decision. See Lonnie H. Stout, 42 Van Natta 2548 (1990).

ORDER

The Referee's order dated March 15, 1991 is affirmed in part and reversed in part. The order is reversed to the extent that it determined that the Referee was without jurisdiction to review the dismissal of claimant's application for Director's review of his vocational assistance matter. We conclude that we have jurisdiction to review the dismissal, and we affirm the Directors Order of Dismissal. The remainder of the order is affirmed.

In the Matter of the Compensation of
PAUL E. KLUTZ, Claimant
WCB Case No. 91-01188
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of that portion of Referee Otto's order which declined to find that it was entitled to an offset of benefits for an alleged overpayment of temporary disability benefits. On review, the issue is offset. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact," with the following supplementation. By stipulated order dated August 24, 1987, the parties agreed that SAIF was entitled to an offset for overpaid temporary disability in the amount of $2,812.50. That order has become final by operation of law.

CONCLUSIONS OF LAW AND OPINION

At hearing, SAIF asserted entitlement to an offset of $4,796.74 in alleged overpaid temporary disability benefits. The requested offset consisted of two

different amounts: An overpayment of $2,812.50 during 1986 and 1987; and an overpayment of $1,984.24 for the period June 13, 1990 through August 7, 1990. With regard to the latter alleged overpayment, the Referee found that SAIF's letter to claimant dated January 15, 1991 fulfilled the procedural requirements of notification pursuant to OAR 436-60-170. However, he concluded that SAIF had not offered sufficient evidence to establish the actual amount that claimant received during the alleged overpayment period. He therefore, denied that portion of the requested offset. We adopt his opinion on this issue. However, the Referee did not address the offset request for the alleged overpayment of $2,812.50. We do so now.

Alleged Overpayment in the Amount of $2,812.50

A Stipulated Order was received into evidence as Exhibit 9 and made part of the record. The Stipulated Order provides, in pertinent part:

> "The parties agree to settle all issue(s) raised or raisable at this time as follows:
>
> "a. SAIF Corporation's overpayment claim of $2,812.50 is approved. SAIF Corporation may use this overpayment to offset obligations of future permanent partial disability."

The stipulation was signed by all of the parties and subsequently approved by Referee Leahy. The order was not appealed and, thus, became a final order.

Based upon the stipulation, we conclude that SAIF has established entitlement to an offset for overpayment of temporary disability. See Allen L. Frink, 42 Van Natta 2666 (1990). We therefore conclude that SAIF is entitled to an offset in the amount of $2,812.50. See Allen L. Frink, supra; Desi R. Davis, 42 Van Natta 1524 (1990).

Inasmuch as an offset does not reduce compensation within the meaning of ORS 656.382(2), claimant is not entitled to an attorney fee award for successfully defending a portion of the Referee's order that declined to grant SAIF's offset authorization request. Strazi v. SAIF, 109 Or App 105 (1991).

ORDER

The Referee's order dated May 17, 1991 is reversed in part and affirmed in part. That portion which declined to find that the SAIF Corporation was entitled to an offset of benefits in the amount of $2,812.50 for an overpayment of temporary disability benefits is reversed, and SAIF is authorized to offset that amount against future awards of permanent disability. The remainder of the order is affirmed.

March 31, 1992 Cite as 44 Van Natta 534 (1992)

In the Matter of the Compensation of
WILLIAM V. LONG, Claimant
WCB Case Nos. 90-21334 & 91-02180
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Bethlahmy's order which: (1) upheld the insurer's denial of his claim for a low back injury; and (2) upheld the

insurer's denial of his aggravation claim for his current low back condition. On review, the issues are compensability and aggravation.

We affirm and adopt the order of the Referee with the following supplementation concerning the timeliness of his claim for a 1987 injury.

A claimant is required to give the employer written notice of the claim within 30 days of the injury. ORS 656.265(1) and (2). Failure to give notice of the claim within this period bars a claim unless: (1) the employer had knowledge of the injury; or (2) the insurer was not prejudiced by the failure to provide notice; or (3) the carrier has begun payments as required under ORS 656.001 to 656.794; or (4) notice is given within one year of the injury and the claimant had good cause for failing to give notice within 30 days. ORS 656.265(4)(a)-(d); Glory Yankaunskas, 43 Van Natta 670 (1991).

The Referee found that claimant had not given notice of his accident within 30 days and the employer did not have knowledge that his claim was work-related. The Referee further concluded that taking into consideration claimant's degenerative disease, the insurer was prejudiced by his failure to give timely notice of an injury. We agree. The insurer's inability to obtain a medical report in a timely manner following the March 1987 incident was prejudicial. We note in this regard that the insurer had claimant examined by an independent medical examiner within one month from his 1990 claim.

We conclude that the Referee correctly found that the claim was time-barred.

ORDER

The Referee's order dated May 2, 1991, as amended by the May 10, 1991 order, is affirmed.

March 31, 1992 Cite as 44 Van Natta 535 (1992)

In the Matter of the Compensation of
LELA K. MEAD, Claimant
WCB Case No. 89-03163
ORDER ON REVIEW
David C. Force, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum

The SAIF Corporation requests review of that portion of Referee T. Lavere Johnson's order that set aside the Determination Order as premature. Claimant cross-requests review of that portion of the order that declined to award an insurer-paid attorney fee for prevailing against SAIF's affirmative allegation of an overpayment of temporary disability. On review, the issues are attorney fees, premature closure and, alternatively, extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. At the time of hearing, claimant was 49 years old. She has a high school diploma or GED and has completed four years of college. Claimant has 50 degrees of forward lumbar flexion and 20 degrees of right and left lateral lumbar flexion.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that claimant's low back aggravation claim, which included the development of incisional neuromas located on two surgical scars on the lower back, was prematurely closed by the March 24, 1989 Determination Order. We disagree.

A claim for compensation shall not be closed nor temporary disability benefits compensation terminated if the worker's condition has not become medically stationary. ORS 656.268(1). The test for determining whether a worker is medically stationary is whether "further medical improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary when her low back injury claim was closed. ORS 656.266; Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

In this case, claimant injured her low back in February 1979 and underwent corrective surgery in 1982. SAIF accepted the claim, which was ultimately closed by a September 1983 Determination Order. After closure, claimant filed an aggravation claim for a worsened back condition. Her claim was based, in part, on Dr. Grimm's diagnosis of probable incisional neuromas and recommendation of possible surgical exploration. After a period of protracted litigation, the court found the claim compensable and remanded the matter to SAIF. The claim was subsequently closed by a March 24, 1989 Determination Order.

The Referee concluded that the claim was prematurely closed because no physician had ever found claimant medically stationary with regard to her incisional neuromas. The absence of such evidence, however, is due to the fact that claimant sought no medical treatment for the neuromas after Dr. Grimm's probable diagnosis and that no physician has since found the presence of incisional neuromas upon examination. Under the circumstances, we do not believe that claimant has satisfied her affirmative burden of proving that her condition was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, supra. Accordingly, the March 24, 1989 Determination Order is reinstated.

Extent of Permanent Disability

The issue of extent of unscheduled permanent disability was raised by claimant at hearing. The Referee did not address it, however, having found premature claim closure. As we have reversed the Referee's decision and reinstated the Determination Order and since we find the record sufficiently developed, we now address that issue on review.

At the outset, we note that, in her respondent's brief, claimant has requested an award for permanent and total disability. We find no evidence, however, that claimant raised that issue before the Referee. Accordingly, we decline to address it here. See Stevenson v. Blue Cross, 108 Or App 247 (1991).

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 claim was closed by Determination Order on March 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. (WCD

Admin. Order 6-1988). Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

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 48 years is 1. Former OAR 436-35-290(4).

Education

Claimant has obtained a high school diploma or GED and has completed four years of college. Therefore, the appropriate formal education value is 0. Former OAR 436-35-300(3)(a).

Skills

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 SVP level, was that as a respiratory therapist (DOT # 079.361-010). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Training

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 (respiratory therapist). Thus, the appropriate training value is 0. Former OAR 436-35-300(5)(b).

Adaptability

The adaptability value for a claimant who has either returned to modified work or received a work offer 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).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work requires light physical

capacity. Therefore, the appropriate adaptability value is 3. Former OAR 436-35-310(3).

Impairment

Claimant is entitled to the following values for lost range of motion of the spine. Claimant is assigned a value of 4 percent for 50 degrees of forward lumbar flexion. Former OAR 436-35-360(6). For 20 degrees of right and left lateral lumbar flexion, claimant is entitled to a value of 4 percent. Former OAR 436-35-360(9).

For the bilateral posterior fusion surgery performed at L4, L5 and S1, claimant is entitled to a value of 8 percent. Former OAR 436-35-350(3).

To arrive at a total impairment value for claimant's spine, the value for claimant's lost range of motion (8), is combined with the value for his surgery (8), for a total value of 15 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 1 is added to her education value 2, the sum is 3. When that value is multiplied by claimant's adaptability value 3, the product is 9. When that value is added to claimant's impairment value 15, the result is 24 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

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". 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).

After our review of the record, we find no clear and convincing evidence that claimant's disability is greater than that indicated by the standards and, accordingly, decline to award additional disability outside the standards. Accordingly, we find that claimant's total permanent disability is equal to 24 percent. We will not reduce claimant's previous award of 27 percent, however, as SAIF has not requested a reduction. See Daniel M. Alire, 41 Van Natta 752 (1989).

Attorney Fees

On cross review, claimant contends that the Referee erred in failing to award attorney fees related to SAIF's request to offset an overpayment of $11,582.59. We need not address that contention, however, in light our decision and the parties' stipulation that such an overpayment was made if the March 24, 1989 Determination Order is not vacated and set aside. Accordingly, because the Determination Order has been reinstated and upheld, SAIF's request to offset that overpayment is approved.

ORDER

The Referee's order dated June 11, 1991 is reversed. The March 24, 1989 Determination Order is affirmed. Claimant is awarded no additional unscheduled permanent partial disability above that previously awarded. The SAIF Corporation's request to offset an $11,582.59 overpayment against claimant's present and future permanent disability awards is approved.

In the Matter of the Compensation of
ANTONIO OSEGEURA, Claimant
WCB Case Nos. 90-22492 & 90-22491
INTERIM ORDER OF DISMISSAL
Quintin B. Estell, Claimant Attorney
Gail Gage (Saif), Defense Attorney
Davis & Bostwick, Defense Attorneys

The SAIF Corporation, on behalf of Knudsen Vineyards, requested, and claimant cross-requested, review of Referee Myzak's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld SAIF's denial, on behalf of Elton Vineyards, of claimant's "new injury" for the same condition. SAIF/Elton and claimant have submitted a proposed "Disputed Claims Settlement," which is designed to resolve all issues raised or raisable between them in this matter. Specifically, claimant agrees that SAIF's/Elton's denial "shall remain in full force and effect."

We have approved the parties' agreement, thereby fully and finally resolving all issues raised or raisable between claimant and SAIF/Elton. Thus, those issues will not be further addressed on review. However, in approving this settlement, we wish to emphasize that claimant is accepting the possibility that he will not receive compensation from SAIF/Knudsen should, after review of the Referee's order, we find that SAIF/Elton is responsible for this claim. See E.C.D., Inc. v. Snider, 105 Or App 416 (1991); Jack Spinks, 43 Van Natta 1181 (1991).

Pursuant to the settlement, claimant and SAIF/Elton agree that all issues raised or raisable between them shall be dismissed with prejudice. We have approved the parties' agreement, thereby fully and finally resolving their dispute. Consequently, claimant's cross-request for review is dismissed.

Nevertheless, since the request for Board review filed by SAIF/Knudsen remains pending, we retain jurisdiction over this case. Accordingly, this shall be interim, pending our review of the remaining issues, and shall be incorporated into our final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WAYNE V. POINTER, Claimant
WCB Case No. 91-10517
ORDER ON REVIEW (REMANDING)
Larry Dawson, Attorney

Reviewed by Board Members Neidig and Moller.

Claimant, pro se, requests review of Referee Menashe's order that dismissed his request for hearing because claimant did not show cause for his failure to appear at hearing. The insurer has moved the Board for an order dismissing claimant's request for review. Specifically, the insurer contends that claimant has failed to provide it with a copy of his request for review. Furthermore, the insurer argues that claimant also failed to file a timely brief. On review, the issues are motion to dismiss and propriety of the Referee's dismissal. We deny the motion to dismiss and we remand to the Referee.

FINDINGS OF FACT

Claimant requested a hearing on August 8, 1991. A hearing was set for November 5, 1991.

Neither claimant nor his attorney appeared at the hearing. On November 6, 1991, the Referee issued a "Show Cause" order, requiring claimant, within 30 days, to justify his failure to appear at the hearing. Claimant did not respond to the order within thirty days. On December 11, 1991, the Referee issued an Order of Dismissal that concluded that claimant had not shown that his failure to appear at the hearing was justified.

On December 27, 1991, the Board received claimant's December 23, 1991 response to the Referee's order. Claimant stated that he was dissatisfied with the Referee's order and requested that the Order of Dismissal be reviewed. In his letter, claimant stated that he failed to appear at hearing because he had lost the phone number and address of the Hearings Division. Claimant further stated that, when he attempted to contact his attorney, he found that the attorney's phone was disconnected and his office was vacant.

Claimant's letter did not indicate that copies had been provided to the employer or its representatives. On January 3, 1992, the Board mailed a computer-generated letter to all parties acknowledging the request for review.

CONCLUSIONS OF LAW AND OPINION

Motion to dismiss

The insurer argues that claimant did not provide it with a copy of his request for review and claimant also failed to file an appellant's brief on review. We construe the insurer's motion to dismiss as a contention that the Board lacks jurisdiction in this matter. We disagree.

Since the Board's January 3, 1992 acknowledgment letter was mailed to all parties 22 days after the Referee's December 11, 1991 dismissal order, we conclude that it is more probable than not that all parties to the hearing received actual notice of claimant's request for review within the statutory 30-day period. See Denise M. Bowman, 40 Van Natta 363 (1988). Under such circumstances, the Board has jurisdiction to consider claimant's request for review, notwithstanding his apparent failure to provide a copy of his request to all parties. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983); Denise M. Bowman, supra.

The insurer also seeks dismissal of claimant's request for review because he has failed to timely submit an appellant's brief. Yet, the filing of briefs is not jurisdictional. OAR 438-11-020(1); Bonnie A. Heisler, 39 Van Natta 812 (1987). Accordingly, the insurer's motion to dismiss on that ground is also denied.

Propriety of Referee's Dismissal

A Referee shall dismiss a request for hearing if claimant and his attorney fail to attend a scheduled hearing unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 438-06-071(2). A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." OAR 438-06-081. We have previously held that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989). In Luthy, we

treated a post-hearing request to reschedule a hearing as a motion for postponement.

Here, in response to the Referee's December 11, 1991 dismissal order, claimant submitted a December 23, 1991 letter expressing dissatisfaction with the decision. Specifically, claimant contended that he had lost the address and phone number of the Hearings Division and when he attempted to contact his attorney, he found that the attorney's phone was disconnected and his office was vacant.

Considering these circumstances, we interpret claimant's letter as a motion for postponement of the scheduled hearing. Inasmuch as the Referee did not have an opportunity to rule on the motion, this matter must be remanded to the Referee for consideration of the motion. See Ray Eaglin, 43 Van Natta 1175 (1991).

In reaching this conclusion, we note that our decision should not be interpreted as a ruling either upon the credibility of the representation made by claimant or a finding on whether postponement is warranted. Rather, we find that the Referee is the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Eaglin, supra.

Accordingly, the Referee's order dated December 11, 1991 is vacated. This matter is remanded to Referee Menashe to determine whether postponement of claimant's hearing request is justified. In making this determination, the Referee shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the Referee finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the Referee. If the Referee finds that a postponement is not justified, the Referee shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

March 31, 1992 Cite as 44 Van Natta 541 (1992)

In the Matter of the Compensation of
LOLA G. POWERS, Claimant
WCB Case No. 89-16344
ORDER ON REMAND
Jon L. Woodside, Claimant Attorney
Shelley McIntyre (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Powers, 110 Or App 308 (1991). The court reversed our prior order which adopted a Referee's order finding claimant's occupational disease claim for a right shoulder rotator cuff condition compensable because she had established that her work activities were a material contributing cause of her disability and need for medical services. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's January 17, 1990 order with the following supplementation. Claimant's work activities as a shoe repair worker constituted a series of traumatic events which were the major contributing cause of her right shoulder rotator cuff condition.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we adopted the Referee's order which found that claimant's work activities as a shoe repair worker were a material contributing cause of her right rotator cuff condition. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that such a finding established the compensability of her occupational disease claim. Consequently, we affirmed the Referee's order which had set aside SAIF's denial.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that her work activities were the major contributing cause of her condition or the worsening of her underlying condition. Aetna Casualty co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of her condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (February 26, 1992). When there is a dispute between medical experts, we generally give greater weight to the opinion that is more thorough and well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986).

Here, the medical evidence is divided concerning whether claimant's right rotator cuff condition was caused by her work activities. Dr. Cowan, claimant's treating chiropractor, has concluded that claimant's condition is "occupationally related," rather than attributable to "a natural progression of aging." This opinion is shared by Dr. Nelson, consulting orthopedist, who determined that claimant's repetitive work activities as a shoe repair worker for the past four to five years "has been a major contributing factor to her right shoulder condition."

On the other hand, Dr. Peterson, neurologist, and Dr. Fuller, orthopedist, each on behalf of the Western Medical Consultants, related claimant's right rotator cuff condition to the natural progression of aging in an approximately 57-year-old woman. The Consultants performed an independent medical examination, the report of which did not include a discussion of claimant's work activities. Unable to "elicit a history which might suggest the occupational exacerbation of an underlying condition," these physicians concluded that claimant's condition was not occupationally related.

Finally, Dr. Snodgrass, neurologist, opined that claimant developed a degenerative rotator cuff tear "through her age and her normal activities including her reaching upward into cabinets in her home." Once the condition had developed, Dr. Snodgrass stated that an increase in symptoms would be expected with a variety of activities, at home or at work. Dr. Snodgrass' opinion was based on a review of claimant's medical record.

After conducting our review of the aforementioned medical opinions, we find the conclusions offered by Dr. Nelson to be the most persuasive. Unlike Drs. Peterson and Fuller, the report from Dr. Nelson indicates that his opinion was based on an understanding of the effect of claimant's work activities on her right shoulder condition, i.e., "repetitive shoulder abduction, flexion and rotation and working in awkward positions." Inasmuch as Drs. Peterson and Fuller concluded that claimant's condition was not occupationally related, we conclude that a depiction (however brief) of claimant's right shoulder movements while performing her work activities would be necessary to demonstrate a

thorough understanding of the potential causes of claimant's condition. Lacking that description, we consider the opinion from Drs. Peterson and Fuller to be incomplete and unpersuasive.

The opinion offered by Dr. Snodgrass does contain a discussion of claimant's right shoulder movements while performing her work activities. Nevertheless, unlike Dr. Fuller, Dr. Snodgrass did not have the opportunity to personally examine claimant. Moreover, Dr. Snodgrass partially based his disagreement with Dr. Fuller on Snodgrass' contention that the activities initially and specifically described by Dr. Fuller to have caused claimant's symptoms were "only normal activities of daily living." We consider such a contention to be inaccurate in that Dr. Fuller attributed claimant's shoulder discomfort to "overhead reaching, combing her hair or any quick rotary movement." Admittedly, the second cause is a "daily living activity." However, the other movements are equally attributable to claimant's work activities, particularly when Dr. Fuller goes on to conclude in that same initial report that claimant's "occupation as a shoe repair woman has aggravated her condition over many years." In light of these circumstances, we find Dr. Fuller's opinion to be more persuasive than the conclusion offered by Dr. Snodgrass.

Consequently, we find that claimant's work activities were the major contributing cause of her right shoulder condition or its worsening. Therefore, we agree with the Referee that SAIF's denial of claimant's occupational disease claim must be set aside.

In reaching this conclusion, we acknowledge that Dr. Fuller opined that claimant's work activities were "a major contributing factor to her right shoulder condition." (Emphasis supplied). Nevertheless, to be sufficient to establish the compensability of a claim, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" not required). Inasmuch as Dr. Fuller demonstrated a thorough understanding of claimant's right shoulder condition and medical/work history and provided a persuasive opinion relating claimant's condition to her work activities as a shoe repair worker, we hold that claimant has established that her occupational disease claim is compensable under former ORS 656.802.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 6, 1990 order.

IT IS SO ORDERED.

March 31, 1992 Cite as 44 Van Natta 543 (1992)

In the Matter of the Compensation of
JOEL O. SANDOVAL, Claimant
WCB Case No. 91-01081
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

On March 26, 1992, we issued our Order on Review reversing the Referee's order which had awarded temporary disability and assessed penalties and attorney fees for unreasonable claim processing. On our own motion, we withdraw our prior order for reconsideration of the remand portion of our decision. On

reconsideration, we replace our prior order with the following order. The parties' rights of appeal shall begin to run from the date of this order.

The insurer requests review of Referee Baker's order which: (1) found that the insurer improperly terminated payment of temporary total disability compensation; (2) assessed a penalty against the insurer for unreasonable delay or refusal to pay compensation pursuant to ORS 656.262(10); and (3) awarded claimant an attorney fee under ORS 656.382 for unreasonable resistance to the payment of compensation. In its brief, the insurer requests that we admit additional documents into the record which were not admitted at hearing. On review, the issues are remand, entitlement to temporary total disability and penalties and attorney fees. We decline to remand and reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact and supplement those findings as follows.

Subsequent to his compensable injury, claimant moved to Los Angeles, California. On October 20, 1990, the insurer wrote the following letter to Dr. Song, claimant's California treating physician: "We have been advised that you are treating [claimant] in regard to his 10-19-89 injury. Please advise us if he has been released for regular work yet. If so, when. We are currently paying timeloss and need a report on his status. When can we expect him to become medically stationary Will he have any permanent impairment? Please advise us." (Ex. 22).

On November 5, 1990, Dr. Song responded as follows:

> "[Claimant] was last seen on 10-23-90 At this time the doctors physical examination sees minimal tenderness on lumbar sacral area, negative tension signs, M/S intact, DTR are within normal limits. Patient is recommended [sic] to obtain a second opinion for further management since he suffers lumbar back pain for over one year. Patient has been released to go back to work on 6-26-90 and returned to us on 7-11-90 for a check up and then on 7-31-90 when he couldn't return to work because of to [sic] much pain so he was put on disability again by Dr. Song. [Claimant] returned on 8-14-90 for a check up then released again on 8-27-90. On 10-23-90 he returned stating he couldn't work so doctor Haeff M.D. (general practitioner) referred him back to Dr. Song (orthopedic) and at that time is what I mentioned in the above beginning paragraph. At this time Dr. Song would like if you would set up [claimant] with one of your medical doctors to be evaluated [sic] for this condition." (Ex. 23). (Emphasis added).

Pursuant to Dr. Song's request, the insurer sent claimant to Dr. Vandernoot for an independent medical exam (IME). In his report dated December 13, 1990, Dr. Vandernoot opined that claimant was "capable of returning to his usual and customary occupational activities with no work restrictions indicated and was capable of doing so by 11/15/89." (Ex. 24-13).

The insurer terminated claimant's temporary total disability as of December 18, 1990. On January 7, 1991 and March 1, 1991, the insurer wrote to Dr. Song asking him whether he concurred with Dr. Vandernoot's report. By the date of the April 17, 1991 hearing in this matter, Dr. Song had not responded to the insurer's queries. Claimant had left California and moved back to Oregon at the time of the hearing.

CONCLUSIONS OF LAW AND OPINION

Remand

We may remand a case to the Referee for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or App 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). We consider the insurer's request that we admit additional documents into the record as a motion for remand. In this regard, we consider the proffered evidence on review only for purposes of addressing the insurer's remand motion.

The two documents at issue are a communication from Dr. Song concurring with Dr. Vandernoot's report and a Determination Order. The Determination Order has no relevance to the legal question of whether the insurer was entitled to terminate temporary total disability payments. Dr. Song's letter is relevant to the question of claimant's entitlement to temporary disability compensation, in that it lends support to the insurer's contention that temporary total disability was lawfully terminated. However, as discussed below, the record clearly establishes, without the proferred letter from Dr. Song, that claimant's temporary total disability compensation was lawfully terminated. Therefore, we find the record sufficiently developed on that question and deny the motion to remand.

Entitlement to Temporary Total Disability

The Referee concluded that the insurer had improperly terminated temporary total disability compensation because it failed to comply with the requirements of ORS 656.268(3). On review, the insurer argues that it properly terminated temporary total disability because, pursuant to ORS 656.262(4)(b), temporary total disability compensation was not owed for the period of time in question. We agree.

ORS 656.262(4)(b) provides:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control." Or Laws 1990 (Special Session), ch. 2, 15.

Because the legislative intent is evident from the express language of the statute, we need look no further. Whipple v. Howser, 291 Or 475 (1981).[1]

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[1] Although we find this statute unambiguous, in Robert E. Riegel, 44 Van Natta 159 (1992), we noted that there is a single, terse statement in the legislative history explaining ORS 656.262(4)(b). In commenting on the proposed legislation, R. Dwinell, a member of the Labor/Management Committee, testified only that "[If] authorization for time loss is not given by the attending physician, time loss is not owed." Joint Committee Proceedings, May 3, 1990, Tape 1, side B at 160.

Temporary total disability is not due and payable under ORS 656.262(4)(b) if two requirements are met. First, the insurer must have requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease. Second, the physician must be unable to verify the worker's inability to work. The statute is applicable if these two requirements are met unless the worker has been unable to receive treatment for reasons beyond the worker's control.

At the outset, we note that there is no evidence that claimant was unable to receive treatment for reasons beyond his control. The evidence shows that claimant was being regularly treated by Dr. Song.

We conclude that this letter to Dr. Song is unequivocally a request for verification of claimant's inability to work resulting from the injury. This letter stated, "We have been advised that you are treating [claimant] in regard to his 10-19-89 injury. Please advise us if he has been released for regular work yet. If so, when. We are currently paying timeloss and need a report on his status . . ." (Emphasis added).

We further conclude that Dr. Song was unable to verify claimant's inability to work. In his November 5, 1990 reply to the insurer's request for verification, Song recommended the insurer obtain a second opinion. This letter noted that claimant had been released to work by Dr. Song twice previously. Furthermore, although the letter indicated that claimant had pain complaints, it did not state that claimant's work release had been retracted or that he was unable to work.

On the basis of Dr. Song's recommendation that a second opinion be obtained, claimant was sent to Dr. Vandernoot for an IME. Dr Vandernoot examined claimant and concluded that claimant could return to his regular work without restriction.

Relying on Dr. Vandernoot's December 13, 1990 report, the insurer ceased paying temporary total disability as of December 18, 1990. We do not find the insurer's actions to be unreasonable. It had requested verification from the attending physician. Dr. Song was not able to verify claimant's inability to work and claimant was not unable to receive treatment for reasons beyond his control. The requirements of the statute were met. Temporary total disability compensation was not due and payable from the date of Dr. Song's November 5, 1990 letter.

Based on these facts, we find that, pursuant to ORS 656.262(4)(b), temporary total disability compensation was not due and payable after November 5, 1990, the date of Dr. Song's response to the insurer's request for verification.

We have found the insurer's conduct to be permitted by the statutes. No penalties or fees are warranted.

ORDER

The Referee's order dated June 12, 1991 is reversed.

In the Matter of the Compensation of
JACK SPINKS, Claimant
WCB Case Nos. 90-20603, 90-20601 & 90-20602
ORDER ON REVIEW
Max Rae, Claimant Attorney
Darrell Bewley, Defense Attorney
David Horne, Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee McCullough's order that denied claimant's request for temporary disability, less time worked, from March 23, 1989 to mid-June 1989. On review, the issue is temporary disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks temporary disability, less time worked, from March 23, 1989 through the middle of June 1989. He originally sought this compensation from one of three carriers, Aetna Casualty & Surety Company (Aetna), Liberty Northwest Insurance Corporation (Liberty), and Wausau Insurance Companies (Wausau), which were implicated in a prior responsibility dispute concerning claimant's cervical, low back, left shoulder and left wrist conditions. At hearing, however, the Referee granted Wausau's motion to dismiss the request for hearing against it. Wausau had asserted that there was no legal basis upon which claimant could recover from Wausau because its denial of claimant's claim against its insured had been upheld in the prior proceeding. Additionally, after the Referee issued his order in this case, claimant entered into a disputed claims settlement with Liberty, in which he agreed to dismiss his request for Board review in this matter insofar as the order pertained to issues concerning Liberty and its insured. Accordingly, the only issue presented is whether claimant is entitled to benefits for temporary disability from March 23, 1989 to mid-June 1989 in connection with his July 29, 1987 injury claim with Aetna. We conclude that he is not and affirm.

Claimant admitted at hearing that he could neither recall nor establish with any degree of specificity which days he missed from work during the period of claimed disability. He also admitted that he had, in fact, worked some days during that period. Aetna contends that such vague, nonspecific recollections are insufficient to carry claimant's burden of proving when, and to what extent, he was disabled for purposes of establishing entitlement to temporary disability. We agree. ORS 656.266. We add, however, that, notwithstanding the paucity of evidence, claimant has failed to establish a causal relation between his alleged disability and his injury claim with Aetna. Claimant conceded that his alleged time loss was due to his low back problem, not his accepted neck injury. Because Aetna has neither accepted nor been found responsible for claimant's low back condition, it is not liable, in connection with the 1987 neck injury claim, for any temporary disability claimant may have suffered from March 23, 1989 through mid-June 1989.

ORDER

The Referee's order dated March 28, 1991 is affirmed.

In the Matter of the Compensation of
WALTER D. VAIL, Claimant
WCB Case No. 91-00991
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

Claimant requests review of Referee Brown's order which upheld the SAIF Corporation's "back-up" denial of claimant's claim for a right knee injury. On review, the issue is the propriety of SAIF's "back-up" denial. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings with the following correction and supplementation.

In paragraph 7 of the Referee's findings, the pronoun "she" refers to Mandy Roper.

Claimant admits that he made the phone call to Mandy Roper which Candy Adkins listened in on. (Tr. 77).

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch. 2, 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

Amended ORS 656.262(6) allows an insurer two years from its good faith acceptance of a claim in which to deny the claim if evidence is obtained which indicates that the claim is not compensable. If the worker requests a hearing on the denial, the insurer must prove by clear and convincing evidence that the claim is not compensable. Id. To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 402 (1987).

The Referee found witnesses Adkins and Utley more persuasive than claimant. Their testimony, taken together, tended to prove that claimant had filed a fraudulent claim. The Referee also found some of claimant's testimony, and the histories given to medical providers, to be inconsistent. The Referee, therefore, concluded that SAIF had sustained its burden of proof. Although we do not find the histories claimant gave to medical providers materially inconsistent, we agree that SAIF had sustained its burden of proof.

In exercising de novo review, we generally defer to the referee's determination of credibility when it is based on the referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360, 363 (1982). However, when the referee's conclusion is based not on demeanor, but on an objective evaluation of the substance of a witness' testimony, the referee has no greater advantage in determining credibility than we do. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Davies v. Hamel Lumber Company, 67 Or App 35, 38 (1984). After our de novo review of the record, we find no reason to reject the Referee's credibility findings.

Utley, age 15, testified that on the evening of the injury he and claimant were playing basketball. Utley testified that he left to go to a youth group

and claimant was still out on the basketball court. When Utley returned at 9 or 9:30 p.m., claimant had an ice pack on his knee. Claimant told Utley he hurt his knee playing basketball. The next morning Utley's mother (Mandy Roper) woke him and told him to go to work with claimant. Utley stated that claimant told him on the way there not to say anything about his knee. Claimant then spoke to his boss about a work-related injury to his knee.

Candy Adkins was a co-worker of Mandy Roper. In early January 1991, Adkins testified that a man who said his name was Walter called Roper at work. Adkins answered the phone. Roper asked Adkins to listen in on the call. Adkins overheard "Walter" say, "Why did you turn me in?" Adkins testified that Roper answered, "I don't know what you're talking about." "Walter" then answered, "You're the only one that could have known." Adkins testified that claimant had called Roper at work on previous occasions and she recognized his voice. (Tr. 29). Claimant admits that he was the caller Candy Adkins overheard on the telephone. (Tr. 77).

The testimony of Adkins and Utley, combined with claimant's inability to adequately explain the statements which Adkins overheard, persuade us that SAIF has sustained its burden to prove by clear and convincing evidence that this claim is not compensable.

We are not persuaded by claimant's arguments that Roper wanted to get back at him for the break up of their relationship and convinced Utley to lie about claimant's injury. Utley testified he has been living in Washington with his father since claimant and Roper broke up. Moreover, Utley's testimony, which was found credible by the Referee, indicates that Utley was uncomfortable with his mother's involvement in perpetuating what Utley believed was a false claim. (Tr. 42).

For these reasons, we decline to alter the Referee's credibility findings and we conclude that SAIF has carried its burden to prove that it is highly probable that claimant's knee condition is not compensable.

ORDER

The Referee's order dated April 30, 1991 is affirmed.

March 31, 1992 Cite as 44 Van Natta 549 (1992)

In the Matter of the Compensation of
NORMAN L. WINTER, Claimant
WCB Case No. 89-14002
ORDER ON REMAND
Aspell, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Bowers Excavating v. Winter, 110 Or App 44 (1991). The court reversed our prior order, Norman L. Winter, 43 Van Natta 144, 1704 (1990), which found claimant's occupational disease claim for a back condition compensable because he had established that his work activities were a material contributing cause of his increased back symptoms. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our January 24, 1991 order with the following supplementation. Claimant's work activities were not the major contributing cause of a worsening of his underlying back condition.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we found that claimant's work activities as a backhoe driver were at least a material contributing cause of his increased back symptoms. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that such a finding established the compensability of his occupational disease claim. Consequently, we reversed the Referee's order which had upheld the insurer's denial. In addition, we found that claimant's pacemaker surgery was a necessary prelude to claimant's eventual back surgery. Reasoning that the pacemaker surgery was a natural consequence of claimant's compensable back condition, we also found the insurer responsible for the pacemaker surgery under former ORS 656.245.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that his work activities were the major contributing cause of his condition or the worsening of his underlying condition. Aetna Casualty co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of a claimant's condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (February 26, 1992). Considering the existence of claimant's preexisting degenerative back condition, we conclude that the causation issue is a complex medical question requiring expert medical evidence to resolve. Uris v. Workers' Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 rev den 300 Or 546 (1986).

Claimant's treating orthopedist, Dr. Balme, concluded that claimant's work activities as a heavy equipment operator "significantly" contributed to his underlying arthritic low back condition. In reaching this conclusion, Balme dismissed claimant's prior juvenile Scheuermann's disease and gout as potential contributors to his current condition. However, Dr. Balme acknowledged that, once there is "an established problem," obesity can contribute to the progression of an arthritic condition.

Dr. Fuller, orthopedist, performed an independent medical examination. Although finding that claimant's degenerative low back condition had worsened over the course of his 16 years with his employer, Fuller concluded that claimant's work activities were not the major cause of that progression. As other contributing factors, Dr. Fuller listed claimant's degenerative arthritic condition, his longstanding gout, and his "generally overweight" condition "over the years." In light of these "variables," Dr. Fuller did not regard claimant's work activities as the major cause of claimant's degenerative arthritis.

Dr. Tennyson, neurologist, examined claimant's medical record. After completing his review, including reports authored by Dr. Balme and Dr. Fuller, Tennyson "agree[d] completely" with Dr. Fuller's opinion. Dr. Tennyson further testified that the contributory factors to the progression of claimant's degenerative condition were the passage of time, overweightness, a congenital

anomaly, his history of gout, and his juvenile Scheurmann's Disease. In Dr. Tennyson's opinion, claimant's condition would have been the same regardless of his work activities.

In our prior order, we rejected the opinions of Drs. Fuller and Tennyson primarily because neither addressed the then-existing compensability standard as to whether claimant's work activities were a "material" contributing cause of his increased symptoms. Inasmuch as the proper standard is whether claimant's work activities were the "major" contributing cause of a worsening of his underlying condition and since each physician addresses that question, we decline to reject their opinions on that basis. In addition, in light of Dr. Tennyson's testimony, we do not consider his opinion concerning the causation of claimant's current condition to be incomplete and conclusory as we previously found.

Considering the number of potential significant causes for claimant's current condition as persuasively identified by Drs. Fuller and Tennyson, we are unable to conclude that claimant's work activities were the major contributing cause of the worsening of his underlying back condition. Consequently, we agree with the Referee that the insurer's denial should be upheld.

Moreover, even if we were to totally discard the Fuller and Tennyson opinions, we would find Dr. Balme's opinion insufficient to satisfy the statutory requirement for compensability of an occupational disease claim. In this regard, we acknowledge that Dr. Balme concluded that claimant's work activities were a "significant" contribution to the worsening of claimant's athritic condition. We further recognize that "magic words" are not required to establish the compensability of a claim. Liberty Northwest Insurance Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, 77 Or App 412 (1986). Nevertheless, in light of Dr. Balme's recognition of the contribution of claimant's obesity to his arthritic condition, we are not persuaded that claimant's work activities, when compared to all other conditions, explanations, or exposures combined, were the major contributing cause of a worsening of his underlying back condition.

Finally, since we have found that claimant's low back condition is not compensable, it follows that his pacemaker surgery, which was performed as a necessary prelude to his low back surgery, is likewise not compensable. Therefore, we also agree with the Referee's decision to uphold the insurer's denial of the pacemaker surgery.

Accordingly, on reconsideration, the Referee's order dated January 17, 1990 is affirmed.

IT IS SO ORDERED.

March 31, 1992 Cite as 44 Van Natta 551 (1992)

In the Matter of the Compensation of
TENNIE M. YOUNG, Claimant
WCB Case No. 91-03407
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of those portions of Referee Thye's order that: (1) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree; and (2) assessed a penalty, with one-half

payable to claimant's counsel in lieu of an attorney fee for SAIF's allegedly unreasonable failure to pay compensation at the correct rate. In her brief, claimant contends that she is also entitled to an assessed attorney fee pursuant to ORS 656.382(1). On review, the issues are rate of scheduled permanent disability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings." We do not adopt the Referee's "Ultimate Finding" that SAIF's failure to pay claimant's award at $305 per degree is unreasonable.

CONCLUSIONS OF LAW AND OPINION

Rate of scheduled permanent disability

We adopt the Referee's "Conclusions and Opinion" on the issue of rate of scheduled permanent disability.

Penalties

The Referee concluded that SAIF's failure to pay claimant at the rate of $305 per degree subsequent to the May 6, 1991 Order on Reconsideration in the Herron case was unreasonable. Alan G. Herron, 43 Van Natta 267 on recon 43 Van Natta 1097 (1991). He, therefore, assessed a penalty with one-half the penalty payable to claimant's counsel in lieu of an attorney fee. See ORS 656.262 (10).

Subsequent to the Referee's order, we concluded that, although the administrative rule relied upon by a carrier was contrary to the Board's holding in Herron, supra, to assess a penalty would penalize a carrier for complying with a valid administrative rule. Mary E. Weaver, 43 Van Natta 2618, 2619 (1991). We noted that, although in Herron the Board gave no effect to the Director's rule, the Board did not declare the rule invalid. Weaver, supra. Accordingly, in the present case, we reverse the Referee's assessed penalty.

Assessed attorney fee

We have above concluded that SAIF's conduct did not amount to an unreasonable resistance to the payment of compensation. Accordingly, an assessed attorney fee pursuant to ORS 656.382(1) is not warranted.

Claimant is entitled to an attorney fee for services on review for successfully prevailing against SAIF's request for review on the issue of rate of scheduled 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 the issue of rate of scheduled permanent disability is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated July 12, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that assessed a penalty, with one-half payable to claimant's counsel, for the SAIF Corporation's allegedly unreasonable failure to pay scheduled permanent disability at the correct rate is reversed. The remainder of the Referee's order is affirmed. For services on review concerning the issue of rate of scheduled permanent disability, claimant's counsel is awarded an assessed attorney fee of $500, payable by SAIF.

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Cite as 110 Or App 162 (1991) December 11, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gordon N. Story, Claimant.

GORDON N. **STORY**, Petitioner,
v.
ASTORIA PLYWOOD CORPORATION and LUMBERMEN'S UNDERWRITING ALLIANCE, Respondents.
(89-04841; CA A67264)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 3, 1991.
Jan H. Faber, Astoria, argued the cause for petitioner. On the brief were H. Patrick Lavis, Martin L. Alvey and Patrick Lavis, P.C., Astoria.
Eric R. Miller, Portland, argued the cause and filed the brief for respondents.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.
JOSEPH, C.J.
Affirmed.
*Joseph, C.J., *vice* Newman, J., deceased.

Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee and denied his claim for compensation. We affirm.

The Board made findings that are supported by substantial evidence. Claimant has long had deep vein vascular incompetency in both legs that caused swelling, episodic ulcers and stasis pigmentation. He was hospitalized in 1987 for treatment of the vascular condition. On September 19, 1988, he injured his right ankle at work when he dropped a 2 x 4 on it. The ankle swelled and ulcerated. Employer accepted the claim as a disabling injury. Subsequently, two doctors reported that the ulcer had healed and that any swelling in the ankle had returned to pre-injury status. On March 1, 1989, while the claim was open, employer sent claimant a letter that said, in part:

> "[W]e have received medical information indicating that your current diagnosis is bi-laterial [sic] deep vein valvular [sic] incompetence. * * * It is our position that further responsibility for time loss benefits and medical care and treatment associated with this pre-existing condition is denied. Unless you can show that the need for treatment currently is due to the contusion to your right ankle, all further Workers' Compensation benefits are denied."

On April 7, a determination order closed the claim and awarded time loss but no permanent disability.

The Board found that claimant's chronic deep vein vascular condition is separate from the injury. It concluded that claimant failed to prove that the injury was a material contributing cause of that condition.

Claimant assigns as error that the Board applied the rule in *Guerrero v. Stayton Canning Co.*, 92 Or App 209, 212, 757 P2d 873 (1988), that, under certain circumstances, an employer may deny responsibility for a condition that it believes is noncompensable while a claim for a compensable condition is still open. 92 Or App at 212. The Board did not err. It found that the vascular condition and the ankle injury were separate conditions and held that employer

could deny compensation for the vascular condition, even though the ankle injury claim had not been closed. That is correct.

Claimant also assigns as error that the Board required him to prove a worsening of the underlying vascular condition. He notes that employer stated in the denial letter that it had "accept[ed] the incident of September 19, 1988, as a temporary exacerbation of your previous deep vein valvular [sic] incompetence." He asserts that he proved that the injury made the condition more symptomatic and that, therefore, the vascular condition itself is compensable. However, even if the injury made the condition more symptomatic, there was substantial evidence that any symptoms attributable to the injury itself had ceased and that the vascular condition had returned to its pre-injury status. Claimant failed to prove that the vascular condition has worsened. *See Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979).

Affirmed.

Cite as 110 Or App 353 (1991) December 18, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jeffrey R. Unterschuetz, Claimant, and In the Matter of the Complying Status of Lance J. and Janet E. Caddy, Employers.

LANCE J. and JANET E. **CADDY**, Petitioners,

v.

SAIF CORPORATION and JEFFREY R. UNTERSCHUETZ, Respondents.

(88-02542 & 88-02543; CA A64059)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1991.

S. David Eves, Corvallis, argued the cause and filed the brief for petitioners.

Kevin N. Keaney, Portland, argued the cause for respondent Unterschuetz. With him on the brief were Lawrence Baron and Pozzi, Wilson, Atchison, O'Leary and Conboy, Portland.

Steve Cotton, Special Assistant Attorney General, Salem, waived appearance for respondent SAIF Corporation.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

In this workers' compensation case, the only question is whether the Caddys, who acted as "general contractors" for the construction of their own home, were employers for purposes of workers' compensation.[1] The Board held that they were, and they seek review.

The Caddys, husband and wife, are in the medical profession. They designed their own home and hired a draftsman to draw up the plans. In order to save money, they acted as their own general contractor. Janet handled all the paper work, and Lance acted "essentially" as job superintendent. Boger, the Caddys' friend, a licensed contractor and a carpenter by trade, handled the carpentry, sought out and selected subcontractors with Janet and helped coordinate scheduling. He also coordinated labor on the job sight. He was paid $17 per hour for his work on the site, but charged nothing for his advice and for helping to

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[1] There is no issue of compensability raised on review.

arrange for subcontractors. He was aware that the Caddys did not have workers' compensation insurance, and he did not consider himself to be their employee.

Boger testified that he worked as much as he wanted and had authority to hire other carpenters to work with him, without approval from the Caddys. Janet testified that she did not believe that she could instruct Boger as to the details of his work or as to whom to hire or fire. The Caddys paid the individuals who worked with Boger separately by the week, at the rate indicated by Boger. They provided no tools and did not supervise Boger or his assistants. They took no withholding from wages and, on the advice of their insurance agent, did not acquire workers' compensation insurance coverage. Claimant was injured while working as a carpenter during construction of the home.

The Board held that the Caddys, through their agent Boger, had the right to control claimant's work and that, therefore, they were his employer. It affirmed the Workers' Compensation Division's determination that the Caddys were noncomplying employers and also held that claimant had suffered a compensable injury.

The Caddys contend that there is no evidence that they had or exercised any control in the manner or method by which Boger or any of the individuals who assisted him went about their work. They exercised only general, "quality oriented" supervision to assure that the work was done well. They argue that that is not enough to permit the conclusion that claimant was their employee, rather than an independent contractor. *See Marcum v. SAIF*, 29 Or App 843, 565 P2d 399 (1977).

That analysis overlooks one inevitability: Because the evidence is uncontradicted that he was not working for himself, claimant must have been working for someone. Boger controlled the details of his work and work hours and had the power to hire or fire him. Janet denied that claimant was working for Boger, who she admitted was her agent when it came to dealing with subcontractors and suppliers. We conclude that there is substantial evidence to support the Board's finding that, acting through Boger, the Caddys hired claimant and controlled his work, and that he was their employee.[2]

The Caddys contend that claimant is, nonetheless, excluded from coverage under the "householder" exemption of ORS 656.027(2):

> "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:
> "* * * * *
> "(2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker."

The Caddys contend that the householder exemption focuses on the private nature of the home and the nonbusiness character of the homeowner's activity and that, because they were not in the business of construction and were not building their home for profit, the exemption should apply. They cite a discussion in 1C Larson, *Workman's Compensation Law* 9-129, Section 50.21 (1974), regarding employment by a nonbusiness employer:

> "The courts have consistently held that compensation acts do not apply in such instances. The examples that can be drawn from decid-

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[2] The question whether Boger was an independent contractor or employee is not determinative or even relevant.

> ed cases cover a range as varied as the hypothetical cases just suggested; a carpenter helping to build or remodel the employer's residence; a practical nurse called in to look after the employer's husband; a handyman working on a country estate; a plasterer redecorating the employer's home; a carpenter building a chicken coop on the employer's residential premises * * *."

We are persuaded that, by making the householder exemption applicable only to work carried on "in or about the private home of the person employing the worker," the legislature has expressed a policy that a householder should not bear all the costs of protecting a worker who comes into the home to perform one of myriad duties that are incidental to home ownership. *Fincham v. Wendt*, 59 Or App 416, 422, 651 P2d 159, *rev den* 294 Or 149 (1982). However, to be exempt, the work must satisfy another requirement as well: It must be of a type similar to the activities listed in the statute, that is, gardening, maintenance, repair or remodeling. We do not agree that work is "similar" under the statute solely by virtue of the fact that it occurs in or about a private home. The characteristic that the listed activities have most in common is that they occur in or about an existing home. Claimant's work on building a home is not similar in that respect. We conclude, therefore, that it does not fall within the exemption. The Board correctly held that claimant is entitled to compensation.[3]

Affirmed.

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[3] ORS 656.029(1) provides, in part:

> "If a person awards a contact involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract[.]"

The Caddys were not in the business of home construction, and they were not, accordingly, required to provide coverage for claimant under that subsection.

Cite as 110 Or App 409 (1991) December 26, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald J. Fendrich, Claimant.

DONALD J. **FENDRICH**, Petitioner,
v.
CURRY COUNTY and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(88-09638; CA A65904))

Judicial Review from Workers' Compensation Board.

Argued and submitted April 15, 1991.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Jon C. Correll, and Malagon, Moore & Johnson, Eugene.

Paul Roess, Portland, argued the cause for respondents. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

DEITS, J.

Reversed and remanded for reconsideration.

*Joseph, C.J., *vice* Newman, J., deceased.

Petitioner seeks review of an order of the Workers' Compensation Board, requesting that it be set aside and that the be case remanded for further proceedings in the light of *Dawkins v. Pacific Motor Trucking*, 308 Or 254 778 P2d 497 (1989).

Claimant injured his back in 1985 and has not worked since leaving his job at that time. His claim was closed in 1986 by a determination order by which he was awarded temporary disability and 35 percent unscheduled disability. In April, 1987, he had surgery. He then sought to have his claim reopened. Employer denied that he had suffered a compensable aggravation. Claimant requested a hearing. The referee set aside the denial and ordered payment of benefits. The referee also found that claimant had neither worked nor sought work. Responding to that order, the insurer paid medical benefits but did not pay temporary disability benefits for lost wages. Claimant then requested a hearing on the denial of temporary disability benefits. The referee found that claimant had "not demonstrated his alleged willingness to accept employment within his limitations." Using the criteria in *Cutright v. Weyerhaeuser*, 299 Or 290, 300, 702 P2d 403 (1985), the referee decided that claimant had withdrawn from the work force and was not entitled to temporary disability benefits. Claimant appealed. The Board affirmed and adopted the referee's order, adding to it a "*See*" citation to *Dawkins v. Pacific Motor Trucking, supra*, 308 Or at 254, a case that had been decided between the issuance of the referee's order and Board review in this case.

Claimant argues that the Board erred in affirming the denial of benefits because, under *Dawkins*, a claimant may be entitled to temporary disability compensation even if he was not working at the time and had not made reasonable efforts to obtain work, if he was willing to work but his physical condition prevented him from seeking employment. Claimant argues that the Board did not address that standard and that the Board's citation of *Dawkins* does not adequately explain its decision.

In *Dawkins*, the Supreme Court clarified the criteria for determining whether a worker has withdrawn from the work force. It held that, when a prior compensable injury makes any attempt to seek employment futile, a worker who is willing to work need not demonstrate efforts to find employment to qualify for disability benefits following an aggravation.

> "A claimant is deemed to be in the work force if:
>
> "a. The claimant is engaged in regular gainful employment; or
>
> "b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or
>
> "c. *The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile.*" 308 Or at 258. (Emphasis supplied; citation omitted.)

The referee here did not find whether claimant was willing to work or whether efforts to find employment would have been futile. Instead, the order focuses only on claimant's lack of effort to obtain employment:

> "A worker is not entitled to temporary disability benefits once he has withdrawn from the work force even if he has been rendered incapable of working due to his compensable injury. *Cutright v. Weyerhaeuser*, 299 Or 290 [,702 P2d 403] (1985); *Karr v. SAIF*, 79 Or

App 250 [,719 P2d 35, *rev den* 301 Or 765] (1986). The question of whether a claimant has withdrawn from the work force is one of fact. *Sykes v. Weyerhaeuser*, 90 Or App 41 [,750 P2d 1171] (1988).

"On October 6, 1988, Dr. Christopher B. Ryan, M.D., wrote that '. . . although [claimant] claims that he wants to return to work, I cannot help but think he would rather be in his comfortably established equilibrium.' Claimant made no effort to work between the time his claim was first closed and the date of his aggravation. *One inquiry about a part-time position* after he was declared medically stationary by his treating surgeon *does not demonstrate his alleged willingness to accept employment within his limitations.* His testimony indicates he does not think he is 'workable'. Thus, I find at the time of the aggravation and thereafter, he had withdrawn from the labor market. I conclude that he is not entitled to temporary disability benefits." (Emphasis supplied.)

The referee's finding that claimant did not "demonstrate his willingness to accept employment" was made in the context of whether he had made reasonable efforts. A worker's efforts may be indicative of a worker's willingness to work, but it is not determinative of willingness to work in all circumstances. Under Dawkins, the definition of "willingness to find employment" is more inclusive. Willingness can also exist if the referee finds that a claimant has a desire to obtain employment and that efforts to obtain it would be futile. Because the necessary findings were not included in the referee's order, the Board needed to do more than add the Dawkins citation to its affirmance.

Employer argues that the order was adequate, because the Board applied the correct legal standard and there was substantial evidence, on the record as a whole, to support the findings. It contends that claimant failed to carry his burden of proof to show that he was willing to work. However, as we have stated:

"In order for us to conduct that kind of review, we must be able to know what the Board found as fact and why it believes that its findings led to the conclusions that it reached. That requires a reasoned opinion based on explicit findings of fact." *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). (Citations and footnote omitted.)

The Board must make findings on whether claimant was willing to work and, if so, whether it would have been futile for him to have sought employment. *See Janisch v. Lane S-D #45*, 106 Or App 218, 806 P2d 218 (1991).

Reversed and remanded for reconsideration.

Cite as 110 Or App 453 (1992) January 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Arnold G. Wheeler, Claimant.

SAIF CORPORATION, Petitioner,
v.
ARNOLD G. **WHEELER**, Respondent.
(WCB No. 87-0276M; CA A64163)

Judicial Review from Workers' Compensation Board.

On respondent's petition for reconsideration filed August 21, 1991. Opinion filed May 22, 1991, 107 Or App 254, 811 P2d 1382.

Gary D. Taylor and Vick & Gutzler, Salem, for respondent.

Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.

JOSEPH, C.J.

Petition for reconsideration allowed; former opinion withdrawn; petition for judicial review dismissed.

Claimant has petitioned for Supreme Court review. 107 Or App 254, 811 P2d 1382 (1991). We treat the petition as one for reconsideration. ORAP 5.15.

Our decision was correct on the merits. ORS 656.278 clearly provides that the Board may terminate an award made before 1966. The more difficult question, raised for the first time in the petition for reconsideration, is whether we have jurisdiction to consider a petition for review of the Board's order. We allow the petition in order to decide that issue.

ORS 656.278(3) provides:

> "The claimant has no right to appeal any order or award made by the Board on its own motion, except when the order diminishes or terminates the former award. The employer may appeal from an order which increases the award."

We have held that, if the Board order does not increase the claimant's award, the statute provides no basis for a petition by the employer. *Morton v. N.W. Foundry*, 36 Or App 259, 584 P2d 346, rev den 284 Or 341 (1978). The question posed by the petition for reconsideration is whether the statute precludes judicial review when the Board's decision is based, not on the merits of the claim, but on its determination that it lacks authority to act.

In *State ex rel Borisoff v. Workers' Comp. Board*, 104 Or App 603, 802 P2d 98 (1990), in which several claimants sought to compel the Board to exercise its own motion jurisdiction to increase their permanent disability awards, we noted in dictum that the claimants could not have sought direct review of the Board's orders, because the orders did not reduce or terminate the existing awards, but merely held that the Board did not have authority to award permanent disability benefits on its own motion. In *Miltenberger v. Howard's Plumbing*, 93 Or App 475, 762 P2d 1057 (1988), we held that a claimant may seek review of a Board determination that it had own motion jurisdiction, as opposed to regular jurisdiction, even though the Board's order did not reduce or terminate the award.

Although our comment in *Borisoff* was *dictum*, it is more closely on point than the holding in *Miltenberger*. The statute allows an employer to file a petition for review only when the Board increases the award. It draws no

distinction between cases that the Board decides on the merits and those that are resolved on some other basis. We conclude that, under ORS 656.278(3), an employer may not seek review of an own motion order that does not increase an award, even if the order is grounded on the Board's determination, perhaps mistaken, that it lacks authority to grant the requested relief.

Petition for reconsideration allowed; former opinion withdrawn; petition for judicial review dismissed.

Cite as 110 Or App 486 (1992) January 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald H. Smith, Claimant.

MEDFORD CORPORATION, Petitioner,
v.
DONALD H. **SMITH**, Respondent.
(89-21043; CA A69499)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 8, 1991.
Jerry K. Brown, McMinnville, argued the cause for petitioner. With him on the brief were Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Claudette L. Yost, Medford, argued the cause and filed the brief for respondent.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Reversed and remanded for reconsideration.

Employer seeks review of an order of the Workers' Compensation Board holding that claimant has established that his employment while employer was self-insured was a material contributing cause of his left wrist carpal tunnel condition and that the claim is compensable as an occupational disease under ORS 656.802(1)(c).

Before July 1, 1988, employer was insured by SAIF. After that date, it became self-insured. Claimant, who worked as a machinist, began complaining about hand problems in February, 1988. In May, 1988, he filed a claim for carpal tunnel syndrome in the *right* wrist, which SAIF accepted. He later experienced pain in his left wrist, and studies in May, 1989, showed the need for left carpal tunnel surgery. On May 11, 1989, he filed a claim with SAIF for left wrist carpal tunnel syndrome. SAIF denied responsibility, claiming that the condition was not related to claimant's employment before July 1, 1988, when it had provided coverage for employer. Claimant did not seek a hearing on SAIF's denial.

The Board found that, although claimant had had some left hand symptoms in the winter of 1987 and the spring of 1988, he did not experience disability, seek medical treatment or receive a diagnosis until after July 1, 1988. It also found that claimant's work after July 1, 1988, could have contributed to the condition. Those findings are supported by substantial evidence. Under *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), the Board correctly held that, in the absence of disability, the date of the onset of the disease is the date on which claimant first sought medical treatment.

Employer argues that, in view of SAIF's previous unchallenged denial of the claim, employer cannot now be held responsible for claimant's work exposure

before July 1, 1988, and, therefore, the Board erred in considering it. We do not understand employer's attempt to distinguish responsibility for "exposure" from responsibility for the disease itself. Although, as a procedural matter, SAIF cannot be held responsible for the claim, employer, *self-insured* after July 1, 1988, can be held responsible for the entire condition, if the considerations that are relevant to the determination of responsibility as between SAIF and employer while self-insured support that conclusion. Among those considerations would be claimant's work exposure, both before and after July 1, 1988, when employer became self-insured.

The parties agree that, in view of *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 844, *rev den* 312 Or 150 (1991), the Board applied the wrong standard and that the correct test is whether the work was the major contributing cause of the condition. Claimant contends that the Board's order should, nonetheless, be affirmed, because there is substantial evidence to support a finding that the work was the major contributing cause. That is for the Board to decide in the first instance on remand.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CHARLES B. **GILL**, JR., and DAVID A. DAVIDSON, Respondents - Cross-Appellants,
v.
STATE ACCIDENT INSURANCE FUND CORPORATION, HERBERT ASCHKENASY, DONALD COOK, HARRIET SHERBURNE, THOMAS SPITZER and DANIEL WILLIAMS, Appellants - Cross-Respondents.
(89C12469; CA A65889)

Appeal from Circuit Court, Marion County.
Albin W. Norblad, Judge.
Argued and submitted September 30, 1991.
William F. Gary, Special Assistant Attorney General, Eugene, argued the cause for appellants - cross-respondents. With him on the briefs were Sharon A. Rudnick, Special Assistant Attorney General, Eugene, Harrang, Long, Watkinson, Arnold & Laird, P.C., Eugene, Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Bruce A. Rubin, Portland, argued the cause for respondents - cross-appellants. With him on the brief were William B. Crow, Portland, and Miller, Nash, Wiener, Hager & Carlsen, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed and remanded on appeal; affirmed on cross-appeal.

Defendants appeal and plaintiffs cross-appeal a judgment for indemnification under ORS 30.285(1).[1] We reverse on the appeal and affirm on the cross-appeal.

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[1] ORS 30.285(1) provides:

> "The governing body of any public body shall defend, save harmless and indemnify any of its officers, employees and agents, whether elective or appointive, against any tort claim or demand, whether groundless or otherwise, arising out of an alleged act or omission occurring in the performance of duty."

The individual defendants are current or former directors of SAIF. In 1987, they brought an action against plaintiffs, who were SAIF's employees, and others. The circuit court granted plaintiffs' motion for summary judgment.[2] Plaintiffs then filed this action, seeking indemnification for attorney fees and costs incurred in defending against defendants' action. The trial court granted plaintiffs' motion for partial summary judgment on the issue of defendants' liability under ORS 30.285(1). During the trial, a witness testified that plaintiffs' defense costs had been paid by their current employer. There is no evidence about whether plaintiffs are responsible for reimbursing the employer.

In an opinion letter, the trial court said:

> "SAIF has raised the issue that their [*sic*] obligation is only to indemnify [plaintiffs] and, in fact, the monies were paid to the law firm by their employees [*sic*] * * *. Therefore, no indemnification is necessary. It is this Court's opinion that SAIF still has the obligation to pay these amounts of money. Whether or not the attorneys were paid by [plaintiffs] or some other person they did, in fact, incur the liability and this Court has no knowledge of the financial relationship in regards to this lawsuit between [plaintiffs] and [their employer]. To rule otherwise would be to unjustly enrich SAIF simply because the actual checks were not written by [plaintiffs]. The defense was hired by [plaintiffs], they incurred the liability and *they somehow saw that this obligation was paid*. SAIF's obligation under the statute is to pay for their costs of defense. They in fact have not done this and do have the obligation to do this." (Emphasis supplied.)

After trial, the court entered a final judgment awarding plaintiffs $173,355.07 as indemnification for attorney fees and costs in the first action.

Defendants assert that plaintiffs are not entitled to indemnity for attorney fees that they did not pay. Plaintiffs argue that "only proof of legal liability, not 'actual loss,' is required for indemnification" under ORS 30.285(1). Both parties rely on contract and common law indemnification cases in support of their arguments. *See, e.g., U.S. Fire Ins. Co. v. Chrysler Motors*, 264 Or 362, 505 P2d 1137 (1973); *Montgomery Elevator Co. v. Tuality Community Hosp.*, 101 Or App 299, 790 P2d 1148, *rev den* 310 Or 243 (1990). Because this case involves a statutory indemnification claim, the parties' reliance on those cases is misplaced.

The Supreme Court discussed statutory indemnification under ORS 30.285(1) in *Aetna Casualty & Surety Co. v. OHSU*, 310 Or 61, 793 P2d 320 (1990). An Oregon Health Sciences University (OHSU) resident doctor allegedly committed malpractice while on rotation to another hospital, which was insured by Aetna. The patient sued the hospital, the doctor, OHSU and the state. Aetna tendered defense of the doctor and the hospital to OHSU. OHSU accepted the tender as to the doctor only, and Aetna defended the hospital. Under a subsequent settlement agreement, Aetna paid $175,000 and OHSU paid $40,000. Aetna then brought an action for indemnification under ORS 30.285(1) for the monies that it had paid in settlement. The trial court dismissed the claim, and the Supreme Court affirmed, holding:

> "ORS 30.285(1), by its terms, inures to the benefit of the public employee only. It does not purport to create any rights in third

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[2] See SAIF v. Montgomery, 108 Or App 93, 814 P2d 536 (1991).

> parties against public agencies or bodies. * * * Moreover, *the doctor himself has no claim under the statute* * * *. Aetna tendered the doctor's defense to OHSU, which accepted it, defended him successfully, and paid money to obtain his full release. One standing in the doctor's shoes has no claim *because the doctor has suffered no loss*. Aetna has no claim under ORS 30.285(1)." 310 Or at 64. (Emphasis supplied.)

The holding in *Aetna* is contrary to the trial court's reasoning here. Furthermore, there is a lack of evidence as to whether plaintiffs suffered any loss. Therefore, we remand for the trial court to reconsider the issue in the light of *Aetna*.[3]

Plaintiffs cross-appeal on the ground that the trial court erred in denying their motion to amend their complaint to add a claim for declaratory and supplemental relief concerning their entitlement to attorney fees and costs that they might later incur in *SAIF v. Montgomery, supra*, n 2. We conclude that, in the light of *Aetna Casualty & Surety Co. v. OHSU, supra*, the trial court did not abuse its discretion in denying the motion.

Reversed and remanded on appeal; affirmed on cross-appeal.

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[3] The bulk of the parties' briefs are dedicated to whether plaintiffs' claims are cognizable under ORS 30.285(1). We need not address those issues in the light of our decision.

Cite as 110 Or App 560 (1992) January 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Harold E. Silvernail, Claimant.

SAIF CORPORATION and COOS COUNTY SCHOOL DISTRICT 54, Petitioners,
v.
HAROLD E. **SILVERNAIL**, Respondent.
(89-08697; CA A67650)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 8, 1991.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Lynne W. McNutt, Coos Bay, filed the brief for respondent.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM
Reversed.

Employer seeks review of an order of the Workers' Compensation Board affirming and adopting the referee's decision that claimant had shown that his work was a "material contribution" to the increased symptoms of his preexisting back condition and, therefore, the condition is compensable as an occupational disease under ORS 656.802(1)(c). In *Aetna Casualty v. Aschbacher*, 107 Or App 494, 812 P2d 844, *rev den* 312 Or 150 (1991), we held that, to establish a compensable occupational disease under ORS 656.802(1)(c), a claimant must show that the work was the major contributing cause of the condition.

Although the Board erred in applying the wrong standard for compensability, it also found, in adopting the referee's order, that claimant had not established that work was the major contributing cause of his worsened condition. There is substantial evidence to support that finding. Claimant conceded in his brief to the Board that, if we were to rule as we subsequently did in *Aschbacher*, employer's denial should be reinstated.[1]

Reversed.

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[1] In his brief to the Board, claimant stated:

> "The referee found that Claimant's work was *not the major contributing cause* of the medically necessary cervical surgery. The referee found that Claimant's work *was a material contributing cause* of need for medical treatment and so was compensable.
>
> "It seems to be admitted by all parties that there was substantial evidence to support the referee's findings.
>
> "* * * * *
>
> "If the *Aschbacher* case is affirmed on appeal, this case should be affirmed. If Aschbacher is reversed and the major contributing cause rule * * * is reinstated, then [the referee's] decision would be reversed."

Although claimant now argues that there is substantial evidence from which the Board could find on remand that the work was the major contributing cause of the worsed condition, there is substantial evidence to support the Board's alternate finding without claimant's concession.

Cite as 110 Or App 577 (1992) January 15, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Karin E. Hoechlin-Cogburn, Claimant.

KARIN E. **HOECHLIN-COGBURN**, Petitioner,
v.
U-LANE-O CREDIT UNION and SAIF CORPORATION, Respondents.
(WCB 89-01135; CA A66908)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 17, 1991.
Christine Jensen, Eugene, argued the cause for petitioner. On the brief were Dale C. Johnson and Malagon, Moore & Johnson, Eugene.
John T. Bagg, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Joseph, Chief Judge, and Richardson* and Deits, Judges.
JOSEPH, C.J.
Affirmed.
*Richardson, J., *vice* Newman, J., deceased.

Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee and denied her mental stress claim. We affirm.

Claimant is a 34-year-old credit union loan officer. She had post-traumatic stress disorder, stemming from an armed robbery at another credit union where she had earlier worked. She began to work for employer in October, 1986. While there, Boone, another loan officer, played practical jokes on her and gossiped about her. Claimant felt compelled to please her co-workers, especially Boone, but was unable to. In the spring of 1988, she complained of headaches, diarrhea, chest and upper left arm pain, insomnia and anxiety. In July, Dr. Gascoyne, a psychologist, prescribed anti-depressants. In August, Dr. Bond, an osteopath, authorized a 1-month medical leave. After claimant returned, she was pressured to participate in a skit at a week-end retreat for employees and later had a verbal encounter with another co-worker. She submitted her resignation on October 28. Thereafter, the symptoms of her preexisting psychological condition returned to their normal lesser frequency.

The Board concluded that claimant did not prove by clear and convincing evidence that her work is a material contributing cause of her psychological condition.[1]

Claimant assigns as error that the Board determined that stressful employee relationships are not properly considered to be a risk of employment. However, the Board did not determine that. It *did* determine that

> "Boone's treatment of claimant was stressful largely because of claimant's inordinate desire to please Boone. This fact persuades us that claimant's relationship with Boone is not the type of association inseparable from the workplace that is properly considered to be a risk of employment. *See SAIF v. Noffsinger*, 80 Or App 640 [, 723 P2d 358] (1986)."

Even if we assume that claimant's conflicts with Boone and others caused her stress and were within the scope of her employment, we agree with the Board that she did not prove her claim.

In *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 844, rev den 312 Or 150 (1991), we held that, to establish a claim under ORS 656.802(1)(c), a claimant must prove that the work was the major contributing cause of an occupational disease. For the reasons stated in that case, we hold that, to establish a mental stress claim under ORS 656.802(1)(b), a claimant must prove by clear and convincing evidence that her work was its major contributing cause. *Semble: City of Portland v. Payne*, 108 Or App 771, 816 P2d 1219 (1991). Claimant has a pre-existing post-traumatic stress disorder and chronic neurotic depression. While working for employer, symptoms of those conditions occurred more frequently and she complained of other symptoms. However, Dr. Holland, a psychiatrist, noted that claimant herself attributed many of her problems to off-work events. While she was working for employer, her father-in-law and her pet died, her parents contemplated divorce, she had gum surgery, her husband had health problems and she had weight loss and other health problems. Holland concluded that her work contributed to but was not the major cause of her mental stress.

The Board concluded that claimant failed to prove by clear and convincing evidence that her work was a *material* contributing cause of her condition. That was the wrong standard. However, it follows from the Board's conclusion that she also failed to sustain the major contributing cause burden.

Affirmed.

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[1] Neither party argued that the proper analysis for claimant's claim was whether her work had caused her pre-existing psychological condition to worsen.

Cite as 111 Or App 27 (1992) January 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Katherine E. Thrash, Claimant.

KATHERINE E. **THRASH**, Petitioner,
v.
CITY OF SWEET HOME and SAIF CORPORATION, Respondents.
(89-15930; CA A69468)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 8, 1991.
Ralph E. Wiser, III, Portland, argued the cause for petitioner. With him on the brief was Bennett & Durham, Portland.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's decision that she is not entitled to benefits for a mental disorder under the provisions of ORS 656.802(1)(b).[1]

Claimant worked as a police officer for the City of Sweet Home. In 1986, she developed a condition that doctors thought was probably multiple sclerosis. Her doctor released her for work driving an ambulance in July, 1986. In March, 1988, she became a full-time dispatcher, employed by the Police Department. Her duties included dispatching for police, fire and ambulance calls. The referee found that the conditions of claimant's employment, including the intimidating management style of the Chief of Police, gave rise to stress beyond that generally inherent in every working situation. There is substantial evidence to support that finding.

---

[1] ORS 656.802 provides, in part:

"(1) As used in this chapter, 'occupational disease' means:
"* * * * *
"(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.
"* * * * *
"(2) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
"(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 May 12, 1989, claimant received a call from a doctor, requesting an ambulance for a 90-year-old patient who was comatose. She neglected to dispatch an ambulance until more than an hour later, when the doctor called a second time. The patient responded well to treatment, but claimant experienced a great emotional distress after the incident, primarily due to her concern that she might be subject to severe discipline. On the advice of her union representative, she did not report the incident to her supervisor. A few days later, the Chief received a letter from the doctor complaining about the incident, and he instigated an investigation. Claimant, unaware of the investigation, continued to work, experiencing stress. She consulted her neurologist, who recommended that she seek psychological treatment.

On June 1, 1989, claimant's supervisor notified her of the investigation and possible disciplinary action. On June 13, 1989, she received a copy of a memorandum from her supervisor to the Chief, recommending several charges of misconduct and a disciplinary hearing. On June 14, claimant told her neurologist that she was under great stress at her job and was facing a disciplinary hearing. The Chief conducted a hearing on June 16 and, on June 20, he decided in writing that claimant had committed misconduct. Claimant does not recall whether she received a copy of that document at that time.

On June 23, claimant filed her claim with City, alleging psychological and physical difficulties, including headaches, insomnia, memory lapses and emotional outbursts. On June 27 or June 28, Dr. Sanders diagnosed claimant's condition as an adjustment disorder with mixed emotional features, "with behavior primarily characteristic of an individual under intense emotional pressure with moderate symptoms of anxiety and depression."

On June 28, claimant was advised that, as discipline for her misconduct in failing to dispatch an ambulance on May 12, she would "be suspended without pay for an equivalent of three days. This suspension will be administered by reducing your monthly pay for the month of July in an amount equal to the three days pay." Claimant understood that as a suspension by which she would be required to work three days without pay. She did not return to work after June 24, and she was later fired because of the unexcused absence.

Dr. Turco examined claimant at SAIF's request. He concluded that she does not have a diagnosable psychological condition, although she does have some work-related stress arising from her relationship with the Chief and the disciplinary action, particularly the expectation of punishment for the May 12 incident. SAIF denied the claim.

The Board found that claimant suffers from an adjustment disorder and that she has experienced real stress in her employment. It concluded, however, that her condition is not compensable as an occupational disease under ORS 656.802(1)(b), because claimant had not established that her employment was a *material contributing cause* of her mental disorder. In *Hoechlin-Cogburn v. U-Lane-O Credit Union*, 110 Or App 577, ___ P2d ___ (1992), we held that, in order to establish a compensable occupational disease under ORS 656.802(b), a claimant must show that the employment is the *major* contributing cause of the disease. *See Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 844, *rev den* 312 Or 150 (1991). We need not remand this case to the Board for reconsideration, however, if there is substantial evidence to support the Board's decision that the employment was not a material contributing cause of the condition, because that would be a determination that claimant had failed to meet a lesser standard of proof than required by *Aschbacher* and *Hoechlin-Cogburn*.

In reaching the conclusion that claimant's condition is not compensable, the Board relied on the opinion of Turco that the disciplinary aspects of the

May incident, particularly the suspension without pay, were a significant factor in causing claimant's stress. It also found that, even apart from the specific discipline ultimately imposed, the disciplinary process in general was a significant factor in claimant's need for treatment. The Board concluded that, as reasonable discipline, those circumstances were excluded from its consideration by ORS 656.802(2)(b) and found that claimant had not established by clear and convincing evidence that her mental disorder arose out of her employment. If the Board was correct it could not consider the disciplinary action that there is substantial evidence to support the Board's finding.

Claimant contends, however, that the actual discipline imposed, which she characterizes as "three days work without pay," was unlawful and therefore unreasonable *per se*, and that the Board should have considered the stress resulting from it in its determination. The Board found that the actual discipline imposed was a reduction in pay, which claimant understood to be three days work without pay.

We are not persuaded by claimant's arguments that the discipline imposed was unlawful as forced labor without compensation. Although the Chief's memorandum could have been a source of confusion, in that it characterized the discipline as a "suspension without pay for an equivalent of three days," it went on to state that the "suspension" was to be implemented by a reduction in pay "in an amount equal to the three days pay." The record supports the Board's finding that the discipline imposed was a reduction in pay for the month. There is no contention that that form of discipline is unlawful. Neither does claimant contend that the discipline imposed was excessive.

Affirmed.

Cite as 111 Or App 71 (1992 January 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dale A. Coombe, Claimant.

DALE A. **COOMBE**, Petitioner,
v.
SAIF CORPORATION and BEAR CAT, INC., Respondents.
(90-03120; CA A69594)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 8, 1991.
Robert L. Chapman, Medford, argued the cause for appellant. With him on the brief was Black, Chapman & Webber, Medford.
Steven R. Cotton, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
DE MUNIZ, J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's decision concerning the rate for claimant's temporary total disability benefits. We affirm.

The facts are generally undisputed, although there are many "gaps" in the evidence. Claimant suffered a compensable low back injury in August, 1984, while working for employer as a truck driver. While he was off work due to the

back condition, he experienced complications of an unrelated abdominal condition that necessitated surgery. He was off work until April 1, 1986, when he was released for light duty. By a determination order on December 15, 1986, claimant was awarded temporary disability benefits at the rate of $319.03 per week from the time of the back injury through November 17, 1986, and an award of 35 percent permanent partial disability. Claimant did not request a hearing on that order.

Some time after his return to work, claimant experienced a recurrence of the preexisting abdominal condition. As a consequence of that and the compensable back condition, he was unable to work steadily and worked only six days during the ensuing 12 weeks, earning a total of $351.02.

On December 23, 1987, SAIF accepted his claim that the abdominal condition had become compensable. Ultimately, claimant was determined to be permanently and totally disabled as a result of that condition. A June, 1989, determination order on the abdominal condition awarded claimant temporary disability benefits from July 7, 1986, through September 14, 1988, at a rate of $123.04 per week, to be credited against the payments that had already been made for the back injury.[1] The referee concluded that SAIF had properly calculated the wage rate for benefits, and the Board affirmed.

The referee and the Board found that the evidence did not clearly describe claimant's earnings at the time of the second injury, and that finding is not challenged. The evidence shows, however, that, at the time of the second injury, his pay was based both on an hourly wage of $9.00 and 23.5 cents per mile driven and that those amounts had not changed since 1984.

At the relevant time, OAR 436-60-020 provided, as pertinent:

> "(6) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210. Monthly wages shall be divided by 4.35 to determine weekly wages. * * *
>
> "(7) Computation of the rate of compensation for workers with minimal earnings and entitled to the lesser amount of 90 percent of wages a week or the amount of $50.00 is as follows: * * *
>
> "(8) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section. The insurer shall resolve situations not covered by ORS 656.210 or this section by contacting the employer and worker to determine a reasonable wage.

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[1] The periods of temporary disability from the two injuries overlapped and, pursuant to OAR 436-60-020(5), SAIF paid claimant at the higher rate of $319.03 from July 7, 1986, through November 17, 1986, as concurrent time loss. At the pertinent time, that rule provided:

> "When concurrent temporary disability is due the worker as a result of two or more claims involving the same worker, the same employer and the same insurer, the insurer may make a pro rata distribution of compensation due under ORS 656.210 without an order by Compliance. The worker shall receive compensation at the highest temporary disability rate of the claims involved."

Claimant concedes that employer complies with that rule.

> "(a) For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exists [sic], insurers shall use no less than the previous four weeks of employment to arrive at an average. *For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker*[.]" (Emphasis supplied.)

The Board viewed this case as fitting within the circumstances described in the emphasized portion of OAR 436-60-020(8)(a), in that extended "gaps" in employment exist within the four weeks preceding claimant's abdominal injury. It found that claimant had not put on sufficient evidence of what the parties intended concerning his wages when he returned to work after the first injury. Claimant does not dispute that finding, but contends only that the Board used the wrong "time of hire."

We are not persuaded that the provisions of OAR 436-60-020(8)(a) are applicable. We nonetheless affirm the Board, because we conclude that its decision is consistent with ORS 656.210(2)(b)(A), which provides that "[t]he benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury." On the basis of information provided by employer and claimant regarding his wages, the Board found that claimant had not met his burden to show that his benefits should be more than the weekly rate of $123.04 that had been paid by SAIF. The record supports that finding.

Affirmed.

Cite as 111 Or App 99 (1992) January 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Thomas F. Scott, Claimant.

SAIF CORPORATION and GENERAL TREE SERVICE, Petitioners,
v.
THOMAS F. **SCOTT**, Respondent.
(89-03612; CA A67752)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 18, 1991.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Steve Brischetto, Portland, argued the cause for respondent. With him on the brief was Baldwin & Brischetto, Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

Employer seeks review of an order of the Workers' Compensation Board that set aside its denial of claimant's occupational disease claim. The issue is whether the order is supported by substantial evidence.

Claimant asserts that he suffers from allergic sensitivities due to his exposure to the chemicals colophony and thiuram during his employment between

July, 1977, and June, 1978. Employer correctly acknowledges that, under ORS 656.202(2) and *Johnson v. SAIF*, 78 Or App 143, 146, 714 P2d 1098, *rev den* 301 Or 240 (1986), the compensability of claimant's disease is controlled by the version of the Occupational Disease Law, that was in effect in 1978. At that time, ORS 656.802(1)(a) provided:

> "(1) As used in ORS 656.802 to 656.824, 'occupational disease' means:
>
> "(a) Any disease or infection which arises out of and in the scope of employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

Claimant bears the burden of establishing that his disease arose out of and in the scope of employment and that it is one to which he was not ordinarily subjected or exposed other than during his employment. *Dethlefs v. Hyster Co.*, 295 Or 298, 307, 667 P2d 487 (1983). If the disease is caused by both on-the-job and off-the-job agents, a claimant must establish that the agent at work was the major contributing cause of the disease. *Dethlefs v. Hyster Co., supra*, 295 Or at 310; *Clark v. Erdman Meat Packing*, 88 Or App 1, 5, 744 P2d 255 (1987), *rev den* 305 Or 102 (1988).

Claimant was raised in the Willamette Valley and has been exposed to pine trees all of his life. In 1975 and 1976, he worked at a dairy in Idaho, tending cows and calves and serving as a handyman. He did not experience any significant skin rashes during that time.

In July, 1977, claimant began working for employer in Portland, spraying pesticides and herbicides and trimming trees and bushes, including pine trees. He frequently wore rubber clothing while working. Within two months, he developed a rash on the back of his neck and soon developed a rash on the back of both hands. By the time that he quit in June, 1978, he had experienced a skin rash on his neck three times and a rash on his hands and, perhaps, on a forearm.

Claimant returned to his previous job in Idaho. On July 2, 1979, he was treated for acute dermatitis on one foot and around several fingers. A physician indicated that the cause was unknown. In September, 1979, claimant was diagnosed as having contact dermatitis associated with his use of iodine solution to wash cow udders. In April, 1980, claimant was found "positive to Thiuram," and a doctor concluded that

> "at least part of his problem may be a rubber allergy. Certainly has used rubber gloves in the past. Evidently this is not the only problem here."

On November 8, 1979, claimant filed a compensation claim in Idaho, alleging that he suffered a "skin rash on hands due to exposure to iodine water used in washing cows." The claim was accepted, and he received time loss for the 12 days of work missed. The Idaho claim was closed, and there is no record that claimant sought to have it reopened or reinstated.

In December, 1980, while in Idaho, claimant suffered a severe eruption of dermatitis on his hands, arms, legs, feet and back. He advised employer that he believed that his condition was due to his exposure to pesticides and herbicides during his work in Oregon. Employer referred claimant to a specialist in toxicology at Oregon State University, who advised him that the contact dermatitis was probably not caused by exposure to chemical agents. Claimant was treated at Oregon Health Sciences University in December, 1980, and January and February,

1981. He continued to suffer skin problems. On November 30, 1988, he was examined by a specialist, who concluded:

> "[Claimant] is totally disabled from chemically induced dermatitis and multiple chemical sensitivities."

Claimant filed his claim for compensation for "chemically induced dermatitis" on his entire body and dated the onset as "1977-1978."

Employer contends that there is not substantial evidence to support the Board's finding that claimant's work for it was the major contributing cause of his chemical sensitivity and dermatitis during and after his employment. We conclude that substantial evidence exists. Claimant's doctor testified that employment with employer was a major cause of the allergy to colophony.

The record also contains substantial evidence that claimant's employment is the major contributing cause of his sensitivity to thiuram, a common ingredient in rubber products and pesticides. The record indicates that he was exposed to rubber clothing for approximately 50 percent of his working time. Employer contends that the record contains no evidence that the specific items of rubber clothing worn by claimant during his employment contained thiuram. However, the presence of thiuram in rubber products as a common ingredient, the degree of claimant's exposure to rubber clothing, the timing of the onset of his symptoms and the results of the 1980 patch test which indicated that claimant was allergic to rubber and thiuram, support the medical opinion that claimant's skin disease was caused by his exposure to rubber clothing. The evidence on causation supports the Board's conclusion that claimant's

> "work at General Spray Service [now General Tree Service] was the major contributing cause of his sensitivity to colophony and thiuram * * *."

Employer argues that claimant was allergic to formaldehyde, which the Board concluded was unrelated to employment, and that he was exposed to colophony and thiuram from other sources off the job.

Medical evidence confirmed that claimant's clinical disease, contact dermatitis, was triggered by his chemical exposure during his employment. There is no evidence that claimant was allergic to formaldehyde until he tested positive during the patch test in 1980, or that the rashes and skin problems during his employment were caused by an allergy to formaldehyde. The evidence supports the Board's finding that claimant's early exposure to thiuram and colophony during employment "remains a material cause of his ongoing skin problems," even though the rashes had temporarily cleared by the time he left employment.

Employer contends that, because claimant received compensation in Idaho for a skin rash on his hands diagnosed as "allergic contact dermatitis," employer is not responsible under *Miville v. SAIF*, 76 Or App 603, 710 P2d 159 (1985). Employer is incorrect. The Board concluded that his Idaho claim was for a condition distinct from the one on which the Oregon claim was made. The Idaho claim was based on a skin rash due to exposure to iodine in the dairy job. The Oregon claim is based on skin problems due to an allergic reaction to colophony and thiuram. *Miville* requires a worker with an accepted Oregon industrial injury claim who suffers a worsening of that injury while working for an out-of-state employer to file a claim concerning the worsened condition in the other state. That rule does not apply here because claimant's Oregon injury is distinct from the out-of-state injury.

Employer also assigns error to the Board's ruling that this claim was timely filed. It argues that the claim is controlled by ORS 656.807 as it read in June, 1978,[1] when claimant left his employment, and that it is barred because it was not filed within five years after the last employment exposure. The Board found that claimant first received notice that his employment was the cause of his dermatitis on December 1, 1988, and the claim was filed on January 2, 1989. We conclude that the claim is controlled by the limitation in effect when the claim was filed.[2] *Holden v. Willamette Industries*, 28 Or App 613, 616, 560 P2d 298 (1977). The Board's findings, which are not challenged by employer, demonstrate that the claim was timely filed under that version of the statute.

Affirmed.

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[1] *Former* ORS 656.807(1) provided:

"Except as otherwise limited for silicosis, all occupational disease claims shall be void unless a claim is filed with the State Accident Insurance Fund or direct responsibility employer within five years after the last exposure in employment subject to the Workers' Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that he is suffering from an occupational disease whichever is later."

[2] ORS 656.807 provides:

"(1) All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:

"(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

"(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease.

"(2) If the occupational disease results in death, a claim may be filed within one year from the date that the worker's beneficiary first discovered, or in the exercise of reasonable care should have discovered, that the cause of the worker's death was due to an occupational disease.

"(3) The procedure for processing occupational disease claims shall be the same as provided for accidental injuries under this chapter."

Cite as 111 Or App 208 (1992) February 12, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Opal L. Scarrioffini, Claimant.

OPAL L. **SCARRIOFFINI**, Petitioner,
v.
MARRIOTT CORPORATION, Respondent.
(WCB 88-07137; CA A66594)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 15, 1991.
James S. Coon, Portland, argued the cause for petitioner. With him on the brief was Imperati, Barnett, Sherwood & Coon, Portland.
Charles L. Lisle, McMinnville, argued the cause for respondent. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.
RICHARDSON, P.J.
Reversed and remanded for reconsideration.
*Joseph, C.J., *vice* Newman, J., deceased.

Claimant sustained a compensable back injury and received an award of 35 percent permanent partial disability. She sought a hearing, and the referee found that she is permanently and totally disabled. The Workers' Compensation Board concluded that she is not totally disabled but increased the permanent partial disability award to 80 percent. Claimant seeks review, and we reverse and remand for reconsideration.

The Board found:

"Claimant, 57 years of age at hearing, has a 9th grade education and no GED. She has worked as a waitress her entire adult life.

"In August 1987, claimant compensably injured her low back while attempting to move a tray from a shelf.

"Claimant was first treated by Dr. Reynolds, family physician, and then referred to Dr. Wade, orthopedic surgeon. Wade released claimant from work. She has not worked since that time.

"Vocational services began in November 1987, but were suspended in January 1988 because of claimant's medical condition.

"Claimant's claim was closed by a February 22, 1988 Determination Order, awarding claimant 35 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of use or function of her right leg. Claimant requested a hearing.

"In April 1988, claimant sought treatment from Dr. Wayson, M.D.

"In July 1988, Dr. Zivin, M.D., performed an independent medical examination.

"Vocational services began again in June 1988. Claimant participated in a physical capacities evaluation, performed by Dr. Slack, M.D., but refused to attend a vocational evaluation on the advice of her attorney.

> "Claimant's physical capabilities include lifting 5 pounds 80 to 100 percent of the time, carrying and pushing/pulling 5 pounds 60 to 80 percent of the time, and very limited bending, squatting, stair/ladder climbing, stooping, reaching above shoulder, kneeling, twisting or crouching. She is restricted totally from unprotected heights and driving automotive equipment, moderately from exposure to marked changes in temperature/humidity and exposure to dust, fumes and gases and mildly from moving around machinery.
>
> "In August 1988, Skilling conducted a vocational evaluation, based only on existing medical opinions and vocational information, including the physical capacities evaluation conducted by Dr. Slack."

On those findings, the Board made these ultimate findings:

> "[1] Claimant is capable of intermittent sedentary work. [2] She has transferable skills. [3] She has not made reasonable efforts to obtain suitable and gainful employment. [4] Claimant suffers moderate permanent impairment resulting from her compensable injury. [5] She has suffered severe loss of earning capacity resulting from her injury."

Claimant contends that the Board's ultimate findings [2] and [3] are not supported by substantial evidence. Finding [2] is that claimant has transferable skills. However, in discussing the extent of claimant's disability, the Board said:

> "After considering claimant's moderate impairment resulting from her compensable back injury, her limited physical capabilities, her age, her *complete lack of transferable skills*, and her limited education, we conclude that claimant suffers 80 percent unscheduled permanent disability resulting from her compensable injury." (Emphasis supplied.)

The Board used, in part, its conclusion that claimant had transferable skills to explain reversal of the referee's award of permanent total disability. Conversely, it used an opposite conclusion to increase the permanent partial disability. The referee had found that claimant lacked transferable skills. There is substantial evidence both to support that conclusion and the opposite one, because there are conflicting vocational evaluations. However, because of the internal inconsistency in the Board's opinion regarding an important fact, we cannot determine what the finding actually is or how to evaluate the Board's reasoning to its conclusion. That inconsistency and inadequacy must be resolved by the Board before we can conduct meaningful review.

In the light of that conclusion, we need not consider the other contentions.

Reversed and remanded for reconsideration.

Cite as 111 Or App 289 (1992) February 12, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Randy R. Westfall, Claimant.

RANDY R. **WESTFALL**, Petitioner,
v.
RUST INTERNATIONAL and UNDERWRITERS ADJUSTING COMPANY, Respondents.
(WCB 88-01147; CA A62442)

On remand from the Oregon Supreme Court, *Westfall v. Rust International*, 312 Or 34, 815 P2d 1272 (1991).
Judicial Review from Workers' Compensation Board.
Submitted on remand August 22, 1991.
David Force, Salem, and Vick & Gutzler, Salem, for petitioner.
Bradley R. Scheminske and Scheminske & Lyons, Portland, for respondents.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Petition for sanctions allowed against David C. Force in the amount of $1,282.50.

This case is before us on remand from the Supreme Court. 312 Or 34, 815 P2d 1272 (1991). The court vacated our award of sanctions made pursuant to ORS 656.390 and remanded for further consideration in light of its opinion in *Mattiza v. Foster*, 311 Or 1, 803 P2d 723 (1990).

In *Mattiza*, the court considered sanctions under ORS 20.105(1), which provides:

> "In any civil action, suit or other proceeding in a district court, a circuit court or the Oregon Tax Court, or in any civil appeal to or review by the Court of Appeals or Supreme Court, the court may, in its discretion, award reasonable attorney fees appropriate in the circumstances to a party against whom a claim, defense or ground for appeal or review is asserted, if that party is a prevailing party in the proceeding and to be paid by the party asserting the claim, defense or ground, upon a finding by the court that the party willfully disobeyed a court order or acted in bad faith, wantonly or solely for oppressive reasons."

One of the issues was whether, when the claim is that the party acted in bad faith, sanctions can be awarded without a finding that the claim or defense was meritless. The court reviewed the legislative history, which indicated that the legislature intended to incorporate the federal bad faith standard referred to in *Alyeska Pipeline Co. v. Wilderness Society*, 421 US 240, 95 S Ct 1612, 44 L Ed 2d 141 (1975), under which a court has inherent equitable power to award attorney fees when an unsuccessful litigant has acted in bad faith. Following the federal interpretation of that rule, the court concluded that a finding of meritlessness was a necessary precursor to an award of sanctions for bad faith under ORS 20.105(1). 311 Or at 8.

The court did not offer any guidance as to its reason for vacating our award of sanctions in this case, and it is not readily apparent whether or how we are to apply *Mattiza's* interpretation of ORS 20.105(1) to the workers' compensation sanctions statute at issue here. ORS 656.390 provides:

> "Notwithstanding ORS 656.236, if either party appeals for review of the claim to the Court of Appeals or to the Supreme Court, or

> files a motion for reconsideration of the decision of the Court of Appeals or the Supreme Court, and the court finds that the appeal or motion for reconsideration was frivolous *or* was filed in bad faith *or* for the purpose of harassment, the court may impose an appropriate sanction upon the attorney who filed the appeal or motion. The sanction may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the appeal or motion, including a reasonable attorney fee." (Emphasis supplied.)

The language of the two sanctions statutes differs substantially. ORS 20.105(1) provides that sanctions may be awarded to the prevailing party if the other party "acted in bad faith, wantonly or solely for oppressive reasons." ORS 656.390 provides for sanctions if the party's appeal or motion for reconsideration "was frivolous or was filed in bad faith or for the purpose of harassment." Thus, a preliminary question for us on remand is whether the test for bad faith in ORS 20.105(1) has any bearing on a request for sanctions under ORS 656.390 for a frivolous appeal. We conclude that it does not.

We first note that this is not a bad faith case;[1] it is a request for sanctions based on the frivolousness of the appeal. The language of ORS 656.390 unambiguously uses disjunctive language to provide for sanctions when the appeal either is frivolous or was filed in bad faith or for the purpose of harassment. We give effect to that disjunctive language and conclude that sanctions may be awarded under ORS 656.390 for a frivolous appeal, even if it was not filed in bad faith or for the purpose of harassment.[2]

Claimant petitioned for review of the Board's decision denying compensation. We affirmed. Respondents moved for sanctions against claimant's attorney, claiming that the petition was frivolous. Counsel for claimant had filed a petition for judicial review of a denied claim.[3] He had signed and filed a brief in which he attempted to couch the assignment of error so that it involved a question of law rather than of fact. However, his only real argument was that the Board should have accepted claimant's testimony and rejected contrary medical evidence. The attorney argued that claimant had testified that his back still hurt, that the referee found his testimony credible and that the condition

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[1] Therefore, we need not address in this case the bad faith language of ORS 656.390.

[2] The Supreme Court's interpretation of "bad faith" in ORS 20.105(1) was based on the legislative intent to adopt the federal common law bad faith standard for sanctions, which includes a requirement that the claim or defense be without merit. As we said in our opinion in *Westfall v. Rust International*, 107 Or App 395, 812 P2d 31 (1991), ORS 656.390 is based on FRCP 11, not on the common law bad faith rule. Under FRCP 11, sanctions are awardable *either* when a pleading, motion or other paper has been interposed for any improper purpose or when it is without merit. *Eastway Const. Corp. v. City of New York*, 762 F2d 243, 254 (2d Cir 1985) *cert den* 484 US 918 (1987); *accord Aetna Life Ins. Co. v. Alla Medical Services, Inc.*, 855 F2d 1470 (9th Cir 1988). The language of ORS 656.390 is consistent with the legislative intent to adopt the FRCP 11 standard. *See also* ORCP 17C; ORAP 13.25.

[3] In our opinion on reconsideration in this case, we held that sanctions could be assessed against an attorney who filed the brief and argued the cause, but did not file the petition for review. *Westfall v. Rust International*, *supra*, 107 Or App at 398. We adhere to that opinion.

was not so complex as to require expert testimony.[4] He also acknowledged that there was competent medical evidence to support both employer's and claimant's views and that "on judicial review pursuant to ORS 656.298, this Court will not disturb the Board's weighing of competing medical opinions, in the record * * *." He further acknowledged that there was substantial evidence to support the Board's decision. He is correct that we will not weigh the medical evidence and that there was substantial evidence to support the Board's order.

Despite counsel's attempt to characterize the petition as presenting an issue of law, the arguments all related to the factual determination and claimant's dissatisfaction with it. Because of the substantial evidence standard of review, which counsel acknowledges, the petition was entirely devoid of factual or legal support. *See Mattiza v. Foster, supra*, 311 Or at 8. Accordingly, sanctions are appropriate in this case.

Petition for sanctions allowed against David C. Force in the amount of $1,282.50.

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[4] Furthermore, his argument that the Board should be bound by the referee's determination of whether the case involved a complex medical issue is entirely without foundation in the light of the Board's *de novo* review authority.

Cite as 111 Or App 325 (1992) February 12, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Bill R. Harrison, Claimant.

BILL R. **HARRISON**, Petitioner,
v.
TAYLOR LUMBER & TREATING, INC., and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(WCB 89-00791; CA A66023)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 17, 1991.
Donald O. Tarlow, Newberg, argued the cause for petitioner. With him on the brief was Brown, Tarlow & Berry, P.C., Newberg.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.
DEITS, J.
Affirmed.
*Joseph, C.J., *vice* Newman, J., deceased.

Claimant seeks review of an order of the Workers' Compensation Board awarding him 18 percent unscheduled permanent partial disability (PPD). We affirm.

Claimant is a 57 year old mill worker. He was working as an edgerman in February, 1987, when he injured his lower back, left leg and hip in a fall. As an edgerman, he operated sawing equipment by pushing buttons either from a standing or sitting position. Occasionally, when a piece of lumber fell to the floor, he had to return it to the conveyor belt. After his fall, he continued to have pain in his left leg and back and eventually had nerve root compression surgery in August, 1988. He was released for work in September, 1988, and has

been working full time since then. He is restricted from lifting more than 10 pounds and from repeated bending and twisting. He continues to experience pain in his back and leg but is able to perform his job. Occasionally, he needs to ask for assistance in putting wood back on the conveyor belt.

On December 21, 1988, a determination order awarded claimant two percent unscheduled PPD. He requested a hearing. In assessing the extent of disability, the referee applied the standards for evaluating disabilities adopted by the Director of the Department of Insurance and Finance pursuant to ORS 656.726(3)(f).[1] Under those standards, the factors of age, education, training and adaptability are given no value in the rating of an unscheduled disability when the worker has returned to his "usual and customary work." *Former* OAR 436-35-290; *former* OAR 436-35-300; *former* 436-35-310. The referee found that

> "claimant has returned to work at his usual job so he does not get a rating for age, education, training and adaptability."

Nevertheless, the referee increased claimant's award to 18 percent PPD. On review, the Board affirmed the award.[2]

In his first assignment of error, claimant contends that the Board's failure to consider his age, education, training and adaptability in calculating the extent of disability is inconsistent with the requirements of the 1987 version of ORS 656.214(5), which provided:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, *the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job.* The term 'education' shall include a worker's skills, training and formal education. The number of degrees of disability shall be a maximum of 320 degrees determined by the extent of the disability compared to the worker before such injury and without such disability. For the purpose of this subsection, the value of each degree of disability is $100." (Emphasis supplied.)

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[1] ORS 656.726 provides,

> "(3) The director [of the Department of Insurance and Finance] hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and 656.001 to 656.794. To that end the director may:
>
> "* * * * *
>
> "(f)(A) Provide standards for the evaluation of disabilities. The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job. The term 'education' shall include the development of an objective standard for evaluating a worker's skills, training and formal education."

[2] The Board concluded that claimant is entitled to 17 percent PPD, but awarded 18 percent, because employer did not request a reduction in the referee's award.

Administrative rules must be consistent with an agency's statutory authority. The agency may not alter, amend, enlarge or limit the terms of an applicable statute by rule. *Cook v. Workers' Compensation Department*, 306 Or 134, 138, 758 P2d 854 (1988). The pertinent rules here are not inconsistent with the agency's statutory authority. ORS 656.214(5) does not require that the factors of age, education, impairment and adaptability necessarily affect the extent of disability in every case, nor does it specify the weight to be given the factors in particular situations. ORS 656.726(3)(f) gives authority to the Director to define standards for evaluating disabilities. The particular rules challenged here were adopted under that authority and are not inconsistent with ORS 656.214.[3]

Claimant next argues that, even if the rules are within the agency's authority, the Board's conclusion that claimant returned to his "usual and customary work" rather than to "modified work" is not supported by substantial evidence and that the Board did not properly explain its conclusion. *Former* OAR 436-35-270(3) provided, in part:

> "(a) 'Usual and customary work': as used in OAR 436-35-290 through 436-35-310 means the job held at the time of injury, or the same job for a different employer;
>
> "(b) 'Modified work': as used in OAR 436-35-290 through 436-35-310 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."

The Board concluded:

> "We have considered claimant's testimony regarding his current work activities and do not find that his current work activities constitute 'modified' work for purposes of applying the standards."

The Board's finding that claimant returned to his usual and customary work is supported by substantial evidence in the record, and the Board's explanation of its conclusion is adequate. The evidence shows that claimant returned to his job as an edgerman. He is able to operate his equipment by pushing buttons and can sit down or stand up as he needs to. The only variation in claimant's work activities since he returned is that it is occasionally necessary for him to have assistance in replacing lumber that has fallen from the conveyor belt.

Claimant next argues that the Board's determination that he is entitled to only 15 percent impairment for disabling pain is not supported by substantial evidence and that the Board did not adequately explain how it reached its conclusion. The referee found:

> "Claimant had [sic] a dull pain in his low back that radiated to his left hip all the time. If he walks or sits for too long or does

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[3] Although not applicable to this case, ORS 656.214(5) was amended in 1989 to refer to the Director's standards:

> "In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. *Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f).*" (Emphasis supplied.)

> strenuous bending or lifting he gets shooting pain that extends from his back to the left hip. Claimant is able to lift up to ten pounds but cannot do repeated bending or twisting. He can sit for one hour if he is able to shift around and stand for one hour if he is able to move around. He can walk, depending on the surface, up to a mile under optimal circumstances. Stair and ladder climbing causes a dull ache and then sharp pain. He cannot run and can drive up to an hour under optimal circumstances."

The Board adopted the referee's findings. It explained its conclusion that claimant was entitled to 15 percent impairment for pain:

> "Disabling pain can result in loss of use of function and when it does, an impairment value may be assessed, even though the standards do not provide for a value range for impairment attributable to disabling pain. *Former* OAR 436-35-010(2) and OAR 436-35-320(1)(a); *Daniel M. Alire*, 41 Van Natta 752, 757 (1989). Since the surgery claimant is restricted to lifting no more than 10 lbs. and is limited when he bends or twists his back. (Ex. 18-4). Claimant can not do many of the personal activities he was accustomed to doing prior to the injury, such as painting his house, refinishing furniture, and playing with his grandchildren. We conclude that the Referee correctly awarded 15 percent permanent impairment for claimant's disabling pain."

That is supported by substantial evidence and is an adequate explanation.

Finally, claimant assigns as error the Board's conclusion that the record does not contain clear and convincing evidence that the degree of his permanent disability is more than 18 percent. A claimant is entitled to prove a greater extent of disability than was determined under the standards, if it can be established by clear and convincing evidence. ORS 656.283(7). Claimant argues that he has sustained an uncompensated loss from "his inability to perform any of the other jobs at the mill that he used to be able to do." He testified that, before his injury, he would sometimes work double shifts or other jobs in order to earn extra pay. The Board concluded:

> "Claimant further contends that clear and convincing evidence exists that the degree of his permanent disability is more than the entitlement indicated by the standards. ORS 656.283(7). After our *de novo* review of the record, we find that claimant has not established that his disability exceeds 17 percent."

That finding is supported by substantial evidence.

Affirmed.

Cite as 111 Or App 571 (1992) February 26, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DANIEL **DURON**, dba Daniel Duron Company, Petitioner,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents.
(89-06-23; CA A66673)

Judicial Review from Department of Insurance and Finance.
Argued and submitted October 28, 1991.
Ted M. Miller, Portland, argued the cause and filed the brief for petitioner.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Peter A. Ozanne, Portland, waived appearance for respondent National Council on Compensation Insurance.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed.
Warren, P.J., dissenting.

Employer seeks judicial review of a final order of the Department of Insurance and Finance (DIF) holding him liable for an additional premium for workers' compensation insurance. We reverse.

Employer is a construction contractor specializing in the installation of roofing. SAIF is employer's workers' compensation insurance carrier. Beginning in 1981, SAIF approved employer's use of three risk classifications for the work activities of his employees. That use continued through 1988. In 1989, SAIF audited employer's 1988 payroll and charged him an additional premium of $5,887.05 for that year. Before the audit, the work activities of the employees affected by SAIF's payroll change were grouped in risk classifications 5645 and 5551. After the audit, SAIF determined that their work activities should all be placed in classification 5551. Employer requested a hearing by DIF, at which he argued that SAIF was not entitled to make an additional assessment for 1988, unless it complied with the requirements of ORS 737.310(12). DIF ruled that SAIF's actions did not fall within the purview of ORS 737.310(12). Employer seeks review of that ruling.

ORS 737.310(12) (*since amended by* Or Laws 1991, ch 768, 1)[1] provides:

> "At the time a workers' compensation guaranty contract is issued, the insurer shall give written notice to the insured of the rating

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[1] ORS 737.310(12) now reads:

> "At the time an insurer issues a workers' compensation insurance policy to an insured for the first time, the insurer shall give written notice to the insured of the rating classifications to which the insured's employees are to be assigned and shall provide an adequate description of work activities in each classification. In the event an insurer recommences coverage following its termination, the notice required under this subsection must be given only if the gap in coverage exceeds six months. The insurer shall bill an insured for reclassifying employees in accordance with rules adopted by the director."

> classifications to which the insured's employees are assigned and shall provide an adequate *description of work activities* in each classification. *The insurer shall not bill an insured for reclassifying employees during the policy year unless*:
>
> "(a) The insured knew or should have known that the employees were misclassified;
>
> "(b) The insured provided improper or inaccurate information concerning its operations; or
>
> "(c) The insured's operations changed after the date information on the employees is obtained from the insured." (Emphasis supplied.)

In holding that ORS 737.310(12) is inapplicable, DIF said:

> "Petitioner argues in its exceptions that the proposed order did not address [the] ORS 737.310(12) exception criteria. However, since SAIF did not base the premium increase which resulted from the premium audit on a reclassification of 'employes' there was no need to address the exceptions to the statute. Respondent SAIF adjusted Petitioner's payroll reports to reflect higher payroll in Class 5551 and lower payroll in Class 5645. SAIF did not change the classification of Petitioner's employes. Petitioner's employes had both of these classifications prior to and throughout the premium year in question. * * * ORS 737.310(12) specifically addresses reclassification of employees. No where [sic] is it articulated that the statute extends to reclassification of payroll."

An administrative agency is not at liberty to limit or restrict the terms of a statute. *Cook v. Workers' Compensation Department*, 306 Or 134, 138, 758 P2d 854 (1988). Clear, unambiguous statutes are to be construed according to their plain meaning. ORS 174.010; *Satterfield v. Satterfield*, 292 Or 780, 782, 643 P2d 336 (1982). Under ORS 737.310(12), classifications for workers' compensation insurance are based on "work activities." "Reclassify" means "to group or segregate into classes again on a new basis" or "to move from one class, classification, or category to another." *Websters Third New International Dictionary* 1896 (unabridged 1976). Thus, the plain meaning of the statute is that reclassification may occur by assigning the work activities to a new classification or by changing the classification from one class to another. "Reclassification" of payroll[2] is simply the means by which the changes are accomplished.

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[2] Although ORS 737.310(12) was not at issue in *Mr. Lustre Car Care v. Nat'l Council on Comp. Ins.*, 99 Or App 654, 783 P2d 1032 (1989), we used the terms "reclassifying employees" and "reclassifying payroll" interchangeably. In that case, the petitioner sought review of an order that denied its "request for *reclassification of a portion of its payroll* for workers' compensation insurance rating." 99 Or App at 656. (Emphasis supplied.) In reciting the facts, we said:

> "After that inspection, petitioner's *employes* performing the clerical and cashiering duties described above *were reclassified* from Code 8810, covering clerical employes, to Code 8387, covering car wash employes. * * * In an inspection amendment, NCCI permitted a *reclassification* from Code 8387 to 8810 *for clerical employes* working only during hours when the car wash was not operating." 99 Or App at 657. (Emphasis supplied.)

DIF's ruling is merely an exercise in semantics. The effect of changing employer's payroll from classification 5645 to 5551 is to change the classification of the work activities of employees on the basis of a different assessment of risk of injury. Under the plain meaning of ORS 737.310(12), that action constitutes a reclassification of the work activities of affected employees. Although employer had incorrectly allocated some of the work activities to classification 5645, ORS 737.310(12) requires SAIF to demonstrate that employer knew or should have known that the employees were misclassified or that the employer had provided inaccurate information or that work activities of the employees changed after 1981. In the absence of such proof, SAIF was not entitled to bill employer for an additional premium for 1988. DIF erred in holding to the contrary.[3]

Reversed.

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[3] The dissent says that ORS 737.310(12) applies only to "reclassification" by assigning work activities to a new classification, as distinguished from assigning work activities from one existing classification to another. That interpretation is premised on the supposition that "[e]ach of [the ORS 737.310(12)(a), (b) and (c) exceptions] relates back to the date of the issuance of the policy." 111 Or App at 576. Contrary to that premise, each of the exceptions relates to the *policy year*, not to the original issuance of the policy. ORS 737.310(12) refers to a reclassification "during the policy year," which in this case was 1988. The issuance of the policy in 1981 is immaterial to SAIF's attempt to charge additional premiums for 1988. Moreover, DIF cannot, by rule (OAR 836-42-060), as suggested by the dissent, limit the statutory requirement for the retroactive assessment of premiums. *See Cook v. Workers' Compensation Department, supra.*

WARREN, P.J., dissenting.

The majority concludes that ORS 737.310(12) (*since amended by* Or Laws 1991, ch 768, 1) precludes SAIF from reallocating employer's payroll among previously assigned rating classifications. Because I do not believe that that statute limits SAIF's authority to reallocate payroll, I dissent.

ORS 737.310(12) provides:

> "At the time a workers' compensation guaranty contract is issued, the insurer shall give written notice to the insured of the rating classifications to which the insured's employees are assigned and shall provide an adequate description of work activities in each classification. The insurer shall not bill an insured for reclassifying employees during the policy year unless:
>
> "(a) The insured knew or should have known that the employees were misclassified;
>
> "(b) The insured provided improper or inaccurate information concerning its operations; or
>
> "(c) The insured's operations changed after the date information on the employees is obtained from the insured."

That statute expressly precludes a workers' compensation insurer from reclassifying an employer's employees, unless one of the three exceptions applies. However, it does not specify what constitutes a reclassification.

The majority states that

> "the plain meaning of the statute is that reclassification may occur by assigning the work activities to a new classification or by changing the classification from one class to another. 'Reclassification' of payroll is simply the means by which the changes are accomplished." 111 Or App at 574. (Footnote omitted.)

Although I disagree with the majority's construction of ORS 737.310(12), I do agree that that statute has a plain meaning.

ORS 737.310(12) governs the assignment of rating classifications. The statute expressly and unambiguously provides that when "a workers' compensation guaranty contract is issued, the insurer shall give written notice to the insured of the rating classifications to which the insured's employees are assigned." The statute then provides that an insurer cannot reclassify employees during the policy year, unless one of three exceptions applies. Each of these exceptions relates back to the date of issuance of the policy. *See* ORS 737.310(12)(a), (b) and (c). At that time, there is no payroll to reallocate. Therefore, the only way a reclassification of employees can occur is by the assignment of a new or substitute rating classification. Because SAIF did not assign employer a new or substitute rating classification, ORS 737.310(12) does not apply.

The majority's construction is also flawed, because it conflicts with the rest of the section. ORS 737.310(10) provides:

> "The director, by rule, shall prescribe the conditions under which a division of payroll between different manual classifications is permitted for purposes of computing workers' compensation premiums."

Pursuant to that grant of authority, DIF's director promulgated OAR 836-42-060, which provides, in part:

> "(1) When there is an interchange of labor the payroll of an individual employee shall be divided and allocated among the classification(s) assigned to the employer provided verifiable payroll records of the employer disclose a specific allocation for each such individual employee.
>
> "(2) When there is an interchange of labor without verifiable records, the entire payroll of employees who interchange shall be assigned to the classification representing any part of their work which carries the highest authorized premium rate."

The term "interchange of labor"

> "means an employee or employees at different times perform duties described by two or more classifications assigned to an employer according to the classification system used by the insurer." OAR 836-42-055(4).

In sum, OAR 836-42-060 permits an employer who has been assigned more than one rating classification to allocate payroll to the different classifications, provided that it maintains verifiable records to substantiate its allocation. If the employer fails to maintain verifiable records for an employee, the insurer can reallocate the payroll for that employee to the highest authorized classification. The only time that a "reallocation" can possibly occur is after

the employer has submitted its total payroll and verifiable records to its workers' compensation carrier. Therefore, an insurer's authority retroactively to adjust an employer's payroll is a necessary adjunct of the statutory and administrative scheme.

The provisions of ORS 737.310(10) indicate that the legislature intended that employers that are assigned more than one rating classification may divide their payrolls. OAR 836-42-060 effectuates that intent but precludes manipulation by enabling insurers to adjust an employer's payroll on the basis of the employer's records. Were the law otherwise, employers could allocate all payroll to the lowest assigned rating classification and then preclude the carrier from challenging that allocation by asserting the reclassification bar of ORS 737.010(12). That would defeat the purpose of the multiple rating classifications and multiple rates.

In construing a statute, we must ascertain the intent of the legislature. ORS 174.020. In pursuing that intent, we must avoid, if possible, a construction that renders part of a statutory scheme meaningless. *Burt v. Blumenauer*, 84 Or App 144, 148, 733 P2d 462, *mod* 87 Or App 263, 742 P2d 626, *rev den* 304 Or 405 (1987). ORS 737.310(10) permits the agency to determine the conditions under which a workers's compensation carrier can allocate payroll dollars among an employer's previously assigned rating classifications. However, the majority's construction of ORS 737.310(12) would preclude reallocation. Accordingly, the majority's construction renders ORS 737.310(10) meaningless.

I dissent.

Cite as 111 Or App 579 (1992) February 26, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Maria Guerra, Claimant.

MARIA **GUERRA**, Petitioner,
v.
SAIF CORPORATION, WINCHELL'S DONUTS, LIBERTY NORTHWEST INSURANCE CORPORATION and DENNY'S, INC., Respondents.
(90-14023, 89-23982, 89-23010; CA A69374)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 14, 1991.
Robert F. Webber, Medford, argued the cause for petitioner. With him on the brief was Black, Chapman & Webber, Medford.
Adam Stamper, Medford, argued the cause for respondents Liberty Northwest Insurance Corporation and Winchell's Donuts. With him on the brief was Cowling & Heysell, Medford.
Steve Cotton, Special Assistant Attorney General, Salem, waived appearance for respondent SAIF Corporation.
No appearance by respondent Denny's, Inc.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board that dismissed her request for a hearing under ORS 656.319(1) as untimely. We affirm.[1]

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[1] Denny's, Inc. was named as a party by mistake but was never formally dismissed as a party. It has taken no part in this proceeding.

On December 26, 1988, claimant injured her back when she slipped and fell while working. At that time, Winchell's Donuts (employer), was insured by Liberty Northwest Insurance Company (Liberty). Claimant filed a claim with employer and Liberty on July 14, 1989. After Liberty questioned the claim, claimant's attorney called the "Employer's Index"[2] and was told that Crawford & Company (Crawford) was employer's carrier. On July 20, claimant notified Crawford of the claim. On September 13, Liberty requested permission from claimant's attorney to contact claimant for a statement. On September 18, claimant's attorney informed Liberty that a statement would not be necessary, because the claim had been made against Crawford. Also on September 18, claimant filed a request for hearing, naming employer and Crawford as parties and alleging that Crawford was not processing the claim in accordance with OAR 438-07-015. On September 22, Liberty denied the claim.

In October, claimant withdrew her request for hearing, and Crawford corresponded with claimant's attorney. On November 13, claimant filed another request for hearing, naming Crawford as the insurer. Accompanying it was a specification of issues that said that the reason for the request was "failure to pay interim [temporary total disability]." On November 29, claimant filed a request for hearing that, for the first time, designated Liberty as the insurer. The request raised Liberty's September 22 denial as an issue. The November 29 request for hearing on the denial was made more than 60 days after the denial. On December 5, Crawford also denied the claim.[3]

Claimant argued that the November 13 request for hearing, showing Crawford as insurer, was timely under ORS 656.319(1) in regard to the first denial. The Board held:

> "In the present case, claimant argues that the November 13, 1989 request for hearing was within 60 days of Liberty's September 22, 1989 denial. Although we agree that the request was made within 60 days, we do not agree that the request constituted an effective request for hearing from Liberty's denial.
>
> "The November 13 request for hearing specified Crawford & Company as the employer's insurer. The request did not raise compensability as an issue and did not refer to Liberty's denial of compensability. On the other hand, the November 29, 1989 request for hearing clearly was a request in response to Liberty's denial of compensability. The November 29 request specified that Liberty was the employer's insurer and the request for hearing was being made against the September 22 denial of compensability.
>
> "A claimant is required to request a hearing in response to each denied claim in order to place the denial before the Referee. *See Naught v. Gamble, Inc.*, 87 Or App 145[, 741 P2d 901] (1987). Here, claimant is not entitled to rely upon her November 13 request for hearing against Crawford and Company as an effective request for hearing from Liberty's denial. *See Richard S. Olson*, 43 Van Natta [657 (1991)]. We, therefore, conclude that claimant's November 29, 1989, request for hearing from Liberty's September 22 denial was untimely."

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[2] The "Employer's Index" is a function of the Department of Insurance and Finance consisting of records of workers' compensation insurance carriers for various employers.

[3] Crawford was not a party before the Board and we ordered that judicial review proceed without it being made a party.

We review for errors of law and substantial evidence. ORS 183.482(8).

Claimant argues that ORS 656.283(3) is controlling and does not require that a request for a hearing correctly name the insurer or specify the issues; therefore, because her November 13 request complies with ORS 656.283(3), it was timely under ORS 656.319(1). Liberty argues that, under ORS 656.262(8), a request for hearing filed because of Crawford's failure to pay interim temporary disability benefits is not a request for hearing on its denial of the claim.

ORS 656.319(1)(a) provides:

> "With respect to *objection by a claimant to denial of a claim* for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:
>
> "(a) A request for hearing is filed not later than the 60th day after the claimant was notified *of the denial* * * *." (Emphasis supplied.)

ORS 656.262(8) (*since amended by* Or Laws 1990, ch 2, 15)[4] provided:

> "If an insurer * * * denies a claim for compensation, written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283, shall be given to the claimant. * * * The worker may request a hearing *on the denial* at any time within 60 days after the mailing of the notice of denial." (Emphasis supplied.)

ORS 656.283(3) provides:

> "A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired, and mailed to the board."

The Board is entitled to some deference in its interpretation of ORS 656.319(1)(a), ORS 656.283(3) and ORS 656.262(8), so long as the interpretation is consistent with the legislature's purpose and with the Board's own rules. *See 1000 Friends of Oregon v. LCDC (Lane Co.)*, 305 Or 384, 390-91, 752 P2d 271 (1988).

Regarding ORS 656.283(3), the Board has promulgated OAR 438-05-070, which provides:

> "Proceedings before the Hearings Division are begun by filing a request for hearing meeting the requirements of ORS 656.283. The request for hearing should be on a form prescribed by the Board. In addition to the information required by ORS 656.283(3), the person requesting a hearing should include the person's full name, the name of the injured worker if different from that of the person requesting the hearing, the injured worker's social security account number, the date of the injury or exposure, the name of the employer

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[4] Because claimant filed a request for hearing before May 1, 1990, and a hearing was convened before July 1, 1990, this case is to be determined pursuant to the law in effect before July 1, 1990. Or Laws 1990, ch 2, 54(2).

> and its insurer, if any, and the claim number. A copy of the request should be mailed to the insurer or self-insured employer."

Claimant does not attack the validity of the rule. Although its language is not mandatory, its intent is to provide for the identification of the subject matter of requests for hearing under ORS 656.283(3). Under the rule, the November 13 request for hearing was deficient, because it does not identify the date of denial, the claim number or Liberty as the insurer. More importantly, a specification of issues was also filed with it that named Crawford as the insurer and listed the failure of Crawford to pay temporary total disability as an issue.

We have said, in a different context, that a claimant has an obligation to request a hearing in response to each denied claim. *See Naught v. Gamble, Inc.*, 87 Or App 145, 149, 741 P2d 901 (1987). When read together, ORS 656.319(1) and 656.262(8) evince a legislative intent that a request for hearing be referable to a particular denial, and ORS 656.283(3), as implemented by OAR 438-05-070, provides the procedural framework to accomplish that objective. The Board's holding is not inconsistent with the legislature's purpose in promulgating the statutes, and we accept the Board's interpretation. Moreover, the Board's decision is supported by substantial evidence that the November 13 request for hearing was directed at Crawford's failure to pay temporary total disability and not at Liberty's denial of the claim.

Claimant next argues that the Board erred in finding that she lacked good cause for filing her request for hearing more than 60 but less than 180 days after the notice of denial. ORS 656.319(1)(b). The Board's findings[5] are supported by substantial evidence, and its decision that the circumstances do not constitute good cause is not erroneous as a matter of law.

Affirmed.

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[5] The Board said:

> "The test for determining if good cause exists has been equated to the standard of 'mistake, inadvertence, surprise or excusable neglect' recognized under ORCP 71B(1) and *former* ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517[, 717 P2d 635], *rev den* 301 Or 666 (1986). Lack of diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237[, 702 P2d 81] (1985). Claimant has the burden of proving good cause. *Id.*
>
> "Claimant contends that she has shown good cause for her untimely filing. Claimant argues that she relied upon information provided by the Employer's Index that Crawford & Company was the appropriate carrier, which led her to initially request a hearing against Crawford, rather than Liberty. We do not agree that claimant's reliance in this case constitutes good cause. Under the circumstances, claimant's reliance upon the Index might have provided an explanation for a delay in the *filing* of her claim, but it does not provide a reasonable explanation for a delay in requesting a hearing.
>
> "Here, claimant was aware of Liberty's September 22 denial, but did not request a hearing from that denial until November 29. In addition, in October, claimant was contacted by Crawford, who reported that they could not identify the injury, did not have a file established and would continue to investigate claimant's case. We conclude that claimant's lack of due diligence does not constitute good cause for her untimely request for hearing. Accordingly, we lack jurisdiction to reach the issue of compensability of her claim against Liberty." (Emphasis in original.)

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Glen D. Roles, Claimant.

SAIF CORPORATION and NORDSTRAND CEDAR, Respondents,
v.
GLEN D. **ROLES**, Petitioner.

In the Matter of the Compensation of Glen D. Roles, Claimant.

GLEN D. **ROLES**, Petitioner,
v.
SAIF CORPORATION and NORDSTRAND CEDAR, Respondents.
(88-19267, 89-06314, 89-14455, 90-02445; CA A63713 (Control), CA A68593)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 25, 1991.
Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief were Jonathan H. Fink and Welch, Bruun & Green, Portland.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed and remanded for proceedings not inconsistent with this opinion.

Claimant seeks review of two Workers' Compensation Board orders that reversed referees' orders awarding claimant temporary total disability benefits (TTD), attorney fees and penalties. We reverse.

Claimant compensably injured his left arm in June, 1980. The claim was closed by a 1982 determination order that awarded him permanent partial disability (PPD). Between 1983 and 1986, the claim was re-opened and re-closed four times. A February, 1984, order granted claimant additional PPD. Subsequent determination orders did not award any additional PPD, but did award him TTD from January 15, 1986, to March 3, 1986. Claimant's requests for hearings on the determination orders were dismissed in September, 1987. After he had received vocational training, a November, 1986, determination order awarded no additional PPD. In March 1987, claimant underwent a surgical procedure, and that claim was closed in February, 1988, without an award of additional PPD.

The Board describes what happened next:

> "On or about February 23, 1988, claimant requested a hearing contesting a February 17, 1988 Determination Order. At the hearing, claimant requested that Referee Michael Johnson set aside four prior Determination Orders, which issued February 8, 1984, February 16, 1984, April 26, 1985, and November 18, 1986. Johnson [set aside the orders and] ordered payment of over $10,000 in what he characterized as temporary total disability compensation [for the period of September 6, 1983, to November 2, 1987]. SAIF did not pay. Claimant requested a hearing, seeking enforcement of Johnson's order. After a February 1989 hearing, Referee Harri ordered SAIF to pay the monies ordered by Johnson and assessed a 25 percent penalty and related attorney fee for SAIF's failure to comply.

> "SAIF did not pay. Claimant requested another hearing, seeking only penalties and related attorney fees. Referee Emerson awarded an additional 15 percent penalty and a related attorney fee for SAIF's failure to comply with Harri's enforcement order.
>
> "SAIF still did not pay. Claimant requested a fourth hearing, seeking penalties and attorney fees for SAIF's continued failure to comply with Harri's order. Referee Podnar, in WCB Case No. 89-14455, noted that Emerson had already penalized SAIF for refusing to comply with Harri's order. Podnar also noted that the most recent order requiring payment of anything other than penalties and associated attorney fees was Harri's. Podnar dismissed claimant's request for a hearing, because he found no basis to award an additional or continuing penalty."

Thereafter, SAIF requested board review of the orders issued by referees Johnson, Harri and Emerson and argued that Johnson did not have jurisdiction, because a timely request for hearing had not been made regarding the determination orders that Johnson had set aside. In its review of Johnson's order, the Board concluded that Johnson had jurisdiction; however, it held for SAIF on the merits and reversed Johnson's award of compensation.[1] On the same day, the Board affirmed Harri's and Emerson's orders,[2] except for the award of penalties. SAIF filed a petition for judicial review of Johnson's order. Claimant moved to dismiss, and SAIF did not oppose the motion. We entered an order of dismissal in October, 1990.

In the meantime, SAIF continued to resist paying claimant TTD, so he sought yet another hearing regarding SAIF's liability for penalties. In March, 1990, Referee Peterson concluded that, under the circumstances, it was not unreasonable for SAIF to refuse to pay TTD and entered an order dismissing the request for hearing.

SAIF sought judicial review of the Harri/Emerson order, which had adopted Johnson's order for TTD. Claimant filed a cross-petition for judicial review but, before we rendered a decision, the Board withdrew its order. The Board then issued an order on reconsideration, in which it concluded that Johnson lacked jurisdiction to issue his order, because claimant's requests for hearing were made more than a year after the determination orders that were the subject of the requests. Therefore, it held that Harri's order requiring SAIF to pay TTD was void. It also said:

> "[E]ven if the issue were not 'jurisdiction' *per se*, Johnson lacked statutory authority to act. It is fundamental that an administrative agency does not have substantive authority beyond that delegated by the legislature. *Former* ORS 656.319(4) provides that a hearing 'shall not be held' if the request for hearing is not timely filed."

On that basis, it concluded that SAIF had not unreasonably resisted the payment of compensation and that SAIF could not be held liable for attorney fees or penalties. On the same day, the Board issued its order regarding Podnar's and Peterson's orders[3] and affirmed the denial of additional attorney fees and

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[1] The Board reversed the portions of Johnson's order that gave rise to the enforcement actions heard by Harri and Emerson. Its order reinstated the four determination orders that Johnson had set aside.

[2] Harri's and Emerson's orders were consolidated for review.

[3] These orders also were consolidated for review.

penalties on the basis of the conclusion that Johnson's order was void.

Claimant seeks judicial review of the Harri/Emerson order on reconsideration and the Podnar/Peterson order. He seeks reinstatement of Harri's and Emerson's orders and additional penalties and attorney fees for SAIF's failure to pay the compensation ordered by Johnson. In the alternative, claimant argues that the Board erred in not ordering SAIF to pay him TTD while Johnson's and Harri's orders were pending on review. Claimant also seeks penalties and attorney fees in connection with those claims. SAIF argues that Johnson's order was void for lack of jurisdiction, because the request for hearing was not timely filed. Therefore, according to SAIF, because the order was a nullity, it could not give rise to a duty to pay the compensation ordered by Johnson or to any subsequent duty to pay TTD.

Johnson's order is not void for want of jurisdiction. A judgment is void only when the tribunal rendering it has no jurisdiction of the parties or the subject matter. *Dolph v. Barney*, 5 Or 191, 211 (1874), *aff'd* 97 US 652 (1878). Subject matter jurisdiction depends on whether the tribunal has the authority to make an inquiry. It exists when a statute authorizes the tribunal to do something about the dispute. *See Callahan v. Employment Division*, 97 Or App 234, 238, 776 P2d 21 (1989). Johnson had authority under ORS 656.708[4] and ORS 656.704(3)[5] to decide the issue in dispute. Although the request for hearing was subject to denial as untimely under ORS 656.268(6)[6] (*since amended by* Or Laws 1990, ch 2, 16; Or Laws 1991, ch 502, 1) and ORS 656.319(4) (*since amended by* Or Laws 1990, ch 2, 24),[7] and Johnson may have erroneously exercised his authority when he denied SAIF's motion to dismiss, his erroneous exercise of that authority did not deprive him of subject matter jurisdiction. *See Goss v. Wilkins*, 80 Or App 241, 721 P2d 884, rev den 302 Or 35 (1986).

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[4] ORS 656.708 provides, in part:

> "The Hearings Division is continued within the board. The division has the responsibility for providing an impartial forum for deciding * * * all cases, disputes and controversies regarding *matters concerning a claim* under [ORS chapter 656]." (Emphasis supplied.)

[5] ORS 656.704(3) provides, in part:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, *matters concerning a claim under [ORS chapter 656] are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue.*" (Emphasis supplied.)

[6] In 1988, ORS 656.268(6) provided, in part:

> "Any * * * party may request a hearing under ORS 656.283 on the determination made under subsection (4) of this section within one year after copies of the determination are mailed."

[7] At the relevant time, ORS 656.319(4) provided:

> "With respect to objections to a determination * * *, a hearing on such objections shall not be granted unless a request for hearing is filed within 180 days after the copies of the determination * * * were mailed to the parties."

The Board's reliance on *Weyerhaeuser v. Roller*, 85 Or App 500, 737 P2d 625 (1987), as support for the proposition that a referee lacks jurisdiction when there is no timely request for a hearing regarding a determination order, is misplaced. Although, in that case, we affirmed a Board order that held that the referee did not have jurisdiction to review a determination order in those circumstances, we did not decide the issue on the basis of subject matter jurisdiction. We held only that the requirement that the parties seek a hearing within one year of the issuance of a determination order was not tolled pending a petition for review of a Board order that held the claim to be noncompensable.

The Board's decision holding Johnson's order void is erroneous. However, that does not aid claimant's cause. When the Board reversed the award of TTD and reinstated the determination orders, and we dismissed the appeal, an award of TTD for the period of September 6, 1983, to November 2, 1987, was precluded.

The Board predicated its denial of TTD, penalties and attorney fees for the periods of time subsequent to Johnson's order on its determination that the order was void. Because it is not void, the Board must now consider whether claimant was entitled to TTD while review was pending before it. See ORS 656.313(1) (*since amended by* Or Laws 1990, ch 2, 23).[8] We remand to the Board to determine the issues of TTD, penalties and attorney fees in the light of our holding that Johnson's order was not void. As a result, we need not discuss claimant's other assignments of error.

Reversed and remanded for proceedings not inconsistent with this opinion.

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[8] At the time of these proceedings, ORS 656.313(1) provided:

"Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."

Cite as 111 Or App 624 (1992) February 26, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

PREMSINGH & ASSOCIATES, INC., Petitioner,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents.
(89-05-25; CA A69469)

Judicial Review from Department of Insurance and Finance.
Argued and submitted November 22, 1991.
Glen S. Shearer, Portland, argued the cause for petitioner. With him on the brief was Schouboe & Furniss, Portland.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief was Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Peter A. Ozanne, Portland, waived appearance for respondent National Council On Compensation Insurance.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Reversed and remanded for reconsideration of status of Stephenson; otherwise affirmed.

Petitioner seeks review of an order of the Department of Insurance and Finance (DIF) that decided that four workers in petitioner's business are employees and not independent contractors.

Petitioner used the services of four workers between October 1, 1987, and September 30, 1988.[1] It considered them independent contractors and, therefore, did not pay premiums for their workers' compensation coverage. During a premium audit, SAIF determined that they were subject employees and, after a hearing, DIF agreed. We review the DIF order for errors of law and substantial evidence. ORS 183.482.

The sole issue is whether DIF erred in concluding that the four workers were employees rather than independent contractors. Petitioner contends that DIF incorrectly applied the law to the facts and should have ruled, as a matter of law, that the workers were independent contractors.

Respondent concedes that DIF's conclusion regarding one of the workers, Stephenson, does not follow from its findings. We agree and remand for reconsideration of his status.

Because this case raises the "subject worker" issue, it was proper for DIF to apply the "right to control" test from *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 769 P2d 215 (1989), and *Henn v. SAIF*, 60 Or App 587, 654 P2d 1129 (1982), *rev den* 294 Or 536 (1983):

> "The test for determining who is a subject worker within the meaning of the Workers' Compensation Act is the employer's right to control

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[1] In 1989, the legislature enacted a statutory formula for determining whether workers are employees or independent contractors. See ORS 701.025. For purposes of this case, however, we apply the law in effect at the time that the material facts occurred.

> the performance of services. * * * The test requires an application of the traditional 'right to control' analysis and a consideration of the 'nature of the work.' * * * Although in some cases there may be questions of fact concerning the employment arrangement between the parties, where * * * the facts are generally undisputed, the question of the nature of the employment relationship is one of law." *Castle Homes, Inc. v. Whaite, supra*, 95 Or App at 271 (Citations omitted.)

The principal factors in the right to control test are: "(1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire." 95 Or App at 272.

DIF found that the evidence was inconclusive on one or more of the factors with respect to the other three disputed workers and it, therefore, turned to the "nature of the work" test, which takes into account

> "the character of the claimant's work or business,--how skilled it is, how much a separate calling or enterprise it is, to what extent it may be expected to carry its own accident burden and * * * its relation to the employer's business, that is, how much it is a regular part of the employer's regular work, whether it is continuous or intermittent, and whether the duration is sufficient to amount to the hiring of continuous services as distinguished from contracting for the completion of a particular job." 1C Larson, *Workmen's Compensation Law* 8-27, 43.52 (1991).

That approach was correct, because the right to control test did not enable DIF to answer the issue. The nature of the work test is a rational method for determining the issue and is consistent with the legislative policy administered by DIF. DIF found the three workers to be employees, because the evidence was still not sufficient to permit it to make a finding that they were independent contractors. Substantial evidence supports the finding. It was petitioner's burden to establish that they were not employees. DIF did not err in applying the tests that it did in reaching its conclusions.

Petitioner contends that, because it put on evidence that the workers were independent contractors, the burden of proof should have shifted to SAIF to prove their employee status. It relies on *Strawn v. Commission*, 1 OTR 98 (1962), *mod* 236 Or 299, 388 P2d 286 (1964), and OEC 307. *Strawn* was a tax appeal that held that a legal presumption of assessment validity shifted the burden of proof to the party challenging the assessment. *Strawn v. Commission, supra*, 1 OTR at 164. Petitioner does not explain, and we do not perceive, how its holding applies to this proceeding.

According to the legislative commentary to OEC 101, "[c]urrently, the rules of evidence except those of privilege do not apply to administrative agencies in contested cases. ORS 183.450." Kirkpatrick, *Oregon Evidence 3* (2d ed 1989). Because OEC 307 is inapplicable to this proceeding, it does not support petitioner's contention.

Reversed and remanded for reconsideration of status of Stephenson; otherwise affirmed.

Cite as 312 Or 463 (1991) December 19, 1991

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of LOIS BOOTH, Claimant.

LOIS **BOOTH**, Petitioner on Review,
v.
TEKTRONIX, INC., Respondent on Review.
(WCB 84-07174; CA A50290; SC S36388)

On review from the Court of Appeals.*
Argued and submitted February 6, 1990.
J. Randolph Pickett, P.C., Portland, filed the petition and argued the cause for petitioner on review.
Barbara A. Brainard, of Stoel Rives Boley Jones & Grey, Portland, argued the cause for respondent on review.
Kathryn H. Clarke, Portland, filed a brief on behalf of amicus curiae Oregon Trial Lawyers Association.
Karen O'Kasey and Janet M. Schroer, of Schwabe, Williamson & Wyatt, Portland, filed a brief on behalf of amici curiae Attorneys for Oregon Association of Workers' Compensation Defense Counsel, Associated Oregon Industries, and Oregon Association of Defense Counsel.
Before Peterson, Chief Justice,** and Carson,*** Jones,**** Gillette, Van Hoomissen, and Fadeley, Justices, and Unis, Justice pro tempore.

*Judicial review from Workers' Compensation Board. 97 Or App 431, 776 P2d 884 (1989).
**Peterson, Chief Justice when case argued
***Carson, Chief Justice when decision rendered.
****Jones, J., resigned April 30, 1990.

CARSON, C.J.
The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.
Unis, J., concurred in part and dissented in part and filed an opinion in which Fadeley, J., joined.

The issues we address in this workers' compensation case arose as the result of claimant's objection to the introduction of evidence obtained by her employer from pre-hearing communications with claimant's treating physicians without prior notice to claimant.[1] The first issue is whether the physician-patient privilege applies to proceedings before the Workers' Compensation Board (the Board) and, if it does apply, whether claimant waived the privilege. The second issue is whether the Board's interpretation of its rules, which allows these pre-hearing communications, was an erroneous interpretation of law. The Court of Appeals affirmed the Board's order without opinion. *Booth v. Tektronix*, 97 Or App 431, 776 P2d 884 (1989). We affirm the decision of the Court of Appeals.

FACTS

Lois Booth (claimant) started working for Tektronix (employer) as an "assembler" on February 14, 1966. She later obtained positions with employer as a quality control inspector and then as a "calibrator." On October 24, 1983,

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[1] This form of communication frequently is labeled "*ex parte* contact," using the term "*ex parte*" to mean "[o]n one side only." Black's Law Dictionary 576 (6th ed 1990).

claimant injured her mid-back and right rib cage while working. In November, claimant's treating physician diagnosed this injury as a pulled muscle or ligament. Claimant filed a claim for a disabling injury which first was accepted and then later denied by employer on the ground that claimant's pain was unrelated to the injury that had occurred at work.

Following the denial in June 1984, another physician examined claimant. At this time, in addition to the rib cage pain, claimant was experiencing pain that radiated down her back. This latter pain eventually was diagnosed as being due to a herniated disc of the spine at the thoracic (chest) level. Upon this physician's request, employer reopened claimant's claim and later rescinded its denial of the claim. In November 1985, she was awarded 25 percent unscheduled permanent partial disability due to the mid-back injury.

Following surgery to correct the herniated disc and alcohol injections to treat her continuing pain after surgery, claimant continued to suffer low-back pain which radiated down her legs. Employer had denied responsibility for claimant's *low-back* problems in May 1985.

After an April 1987 hearing, the referee affirmed the partial denial (low-back) and the award of 25 percent unscheduled permanent partial disability (mid-back). At the hearing, the referee -- over claimant's objections -- admitted seven exhibits consisting of letters describing claimant's condition from three of claimant's treating physicians. The seven letters resulted from five pre-hearing communications by employer's lawyer with these physicians. Employer's pre-hearing communications with the physicians occurred in person, by telephone, and by letters. Employer had not given claimant notice prior to communicating with the physicians.

Claimant requested Board review of the referee's decision. In its decision, the Board relied upon its prior decisions in *Adelbert P. Sheppard*, 39 Van Natta 747 (1987), and *Allen W. Hayes, Jr.*, 37 Van Natta 1179 (1985), wherein the Board held that pre-hearing communications between an employer's lawyer and a claimant's treating physician without prior notice to claimant were permitted by Board rules. Based on those decisions, the Board agreed with the referee that the letters were admissible and that claimant correctly was denied compensation for her low-back problem because it was unrelated to the on-the-job injury. However, the Board found that the referee incorrectly had determined the extent of claimant's permanent disability for her compensable mid-back injury and increased her award from 25 percent to 50 percent unscheduled permanent disability.

Claimant sought judicial review, assigning as error the admission of the evidence that resulted from the communications. In additional assignments of error, claimant argued that, without the challenged exhibits, there was no substantial evidence to support the Board's findings that the low-back problem was not due to her on-the-job injury and that the Board erred in concluding that claimant was only partially, not totally, disabled. The Court of Appeals affirmed the Board's decision without opinion,[2] and claimant sought review in this court.

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[2] The Court of Appeals previously had held, in an opinion on reconsideration, *Mershon v. Oregonian Publishing*, 96 Or App 223, 772 P2d 440, *rev den* 308 Or 315 (1989), that the Board's interpretation of its rules to permit pre-hearing communications between the employer's lawyer and the claimant's physician without prior notice to the claimant was not inconsistent with any statute or rule and thus was entitled to deference.

DISCUSSION

The essence of claimant's argument to this court is that the Board's interpretation of the statutes and rules, which permits the communications at issue, is an erroneous interpretation of the agency's own rules, the workers' compensation statutes, and other provisions of law, thus bringing this case within our scope of review under ORS 656.298(6) and 183.482(8)(a).[3] We first examine the status of the physician-patient privilege in workers' compensation hearings and then review the appropriateness of pre-hearing communications between the employer's lawyer and the claimant's treating physician.

A. *Physician-Patient Privilege*

Claimant argues that the exhibits were inadmissible because the evidence obtained from the pre-hearing communications is protected by the physician-patient privilege, Oregon Evidence Code (OEC) 504-1,[4] and neither statutes nor the Board's own rules provide for waiver of this privilege. Employer responds that the physician-patient privilege is inapplicable in workers' compensation proceedings.

The first step in our analysis is the Workers' Compensation Law, ORS chapter 656. ORS 656.704 provides, in part:

> "(1) Actions and orders of the director, and administrative and judicial review thereof, *regarding matters concerning a claim* under this chapter [Workers' Compensation Law] are subject to the procedural provisions of this chapter and such procedural rules as the *board* may prescribe.

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[3] ORS 656.298(6) provides:

> "The review by the Court of Appeals shall be on the entire record forwarded by the board. Review shall be as provided in ORS 183.482(7) and (8)."

ORS 183.482(7) provides, in part:

> "[T]he court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion."

ORS 183.482(8)(a) provides:

> "The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall: [set aside or modify the order or remand the case.]"

[4] OEC 504-1(2) states:

> "A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications in a civil action, suit or proceeding, made for the purposes of diagnosis or treatment of the patient's physical condition, among the patient, the patient's physician or persons who are participating in the diagnosis or treatment under the direction of the physician, including members of the patient's family."

> "(2) Actions and orders of the director and the conduct of hearings and other proceedings pursuant to this chapter [Workers' Compensation Law], and judicial review thereof, *regarding all matters other than those concerning a claim* under this chapter, are subject only to ORS 183.310 to 183.550 [Administrative Procedures Act] and such procedural rules as the *director* may prescribe. * * *
>
> "(3) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." (Emphasis added.)

The statute references different sources for procedural rules depending upon whether the matter is one, such as the present case, that concerns a claim, or is a matter that does not concern a claim. If the matter concerns a claim, the procedures contained in the Workers' Compensation Law and rules of the Board apply; in contrast, if the matter does not concern a claim, the Administrative Procedures Act (in part) and rules of the director of the Department of Insurance and Finance apply. Because this case involves a claim, the physician-patient privilege could be made applicable by the workers' compensation procedural statutes or by a rule that the Board has prescribed. The parties have cited no such statute or rule to this court, and we have not found such a statute or rule.

Further, ORS 656.283(7), the Workers' Compensation Law provision concerning hearing procedures, provides, in part:

> "Except as otherwise provided in this section and rules of procedure established by the board, the referee is 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."

Accordingly, because the Workers' Compensation Law does not provide that the physician-patient privilege of OEC 504-1 is applicable, the referee was not required by the Workers' Compensation Law to apply OEC 504-1 and to exclude the evidence resulting from the pre-hearing communications.

Claimant argues, nevertheless, that the Oregon Evidence Code and the Oregon Administrative Procedures Act themselves make the privilege applicable. Claimant relies on the Commentary to OEC 101, which describes the applicability of the Oregon Evidence Code. The legislative commentary states:

> "Currently, the rules of evidence *except those of privilege* do not apply to administrative agencies in contested cases. ORS 183.450. Nothing in [OEC] 101 should be construed to alter present Oregon practice under the administrative procedures statutes." Kirkpatrick, Oregon Evidence Code 3 (1989). (Emphasis added.)

In response to claimant's argument, we begin at the place that the commentary to the Oregon Evidence Code suggests that we should begin -- an examination of ORS 183.450.

ORS 183.450(1) provides:

"In contested cases:

> "(1) Irrelevant, immaterial or unduly repetitious evidence shall be excluded but erroneous rulings on evidence shall not preclude agency action on the record unless shown to have substantially prejudiced the rights of a party. All other evidence of a type commonly relied upon by reasonably prudent persons in conduct of their serious affairs shall be admissible. *Agencies shall give effect to the rules of privilege recognized by law.* Objections to evidentiary offers may be made and shall be noted in the record. Any part of the evidence may be received in written form." (Emphasis added.)

This broad mandate incorporates the rules of privilege, including those contained in the Oregon Evidence Code, into contested cases. However, another statute, ORS 183.315, lists certain agencies to which the privilege-protecting statute does not apply. The relevant part of ORS 183.315 is subsection (1), which provides:

> "Except as otherwise provided in subsection (6) of this section [referring to the Public Utility Commission], the provisions of ORS * * * 183.450 * * * do not apply to * * * [the] Department of Insurance and Finance with respect to its functions under ORS chapters 654 and 656 [chapter concerning workers' compensation] * * *."[5]

Consequently, the statute that retains the evidentiary rules of privilege in contested cases (ORS 183.450) specifically does not apply in workers' compensation claim hearings (ORS 183.315(1)).[6] Thus, claimant's argument based on the Oregon Evidence Code and the Oregon Administrative Procedures Act leads us to the same outcome as our analysis of the Workers' Compensation Law.

We conclude that the physician-patient privilege does not apply in a workers' compensation contested case claim hearing. Therefore, the rules of privilege do not make the Board's interpretation, which permits pre-hearing communications between an employer's lawyer and a claimant's physician without prior notice to claimant, incorrect as a matter of law. Consequently, we do not reach the corollary issue of waiver of the privilege.

B. *Pre-hearing Communications Appropriateness*

The fact that the statutes and rules do not provide for the physician-patient privilege in workers' compensation contested cases does not resolve entirely the second question of the appropriateness of pre-hearing communications between claimant's treating physicians and employer's lawyer. Claimant argues also (1) that even if the privilege is inapplicable, other areas of the law recognize and protect the special relationship between a patient and her physician, and (2) that the workers' compensation statutes and agency rules do not contemplate this type of communication.

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[5] As a result of a legislatively-directed agency reorganization in 1987, the language in this subsection, which previously listed the "Workers' Compensation Department," was changed to substitute the "Department of Insurance and Finance with respect to its functions under ORS chapters 654 and 656." Or Laws 1987, ch 373, 21. The Workers' Compensation Board was a part of the predecessor Workers' Compensation Department, ORS 656.708 (1985), and now is within the Department of Insurance and Finance, ORS 656.712(1). The proceedings herein spanned the pre-and post- reorganization periods, a factor of no significance in this case.

[6] A statutory exemption of workers' compensation proceedings from the application of the physician-patient privilege is common among the states. *See* 8 Wigmore, Evidence 2380 (McNaughton rev ed 1961 & Supp 1991).

1.*Policy*

Claimant and *amicus* Oregon Trial Lawyers Association (OTLA) cite many sources recognizing the special relationship between patient and physician outside the context of the evidentiary privilege. These include: (1) The Hippocratic Oath; (2) willful or negligent disclosure of a professional secret as grounds for suspension of, or refusal to grant, a license to practice medicine, ORS 677.190(5); (3) the existence of tort liability for a physician's breach of the confidential relationship under *Humphers v. First Interstate Bank*, 298 Or 706, 696 P2d 527 (1985); (4) the constitutional right to privacy, *see Roe v. Wade*, 410 US 113, 219, 93 S Ct 705, 35 L Ed 2d 147 (1973) (Douglas, J., concurring) ("[t]he right to privacy has no more conspicuous place than in the physician-patient relationship, unless it be in the priest-penitent relationship"); and (5) ethical obligations of lawyers when approaching a plaintiff's physicians in personal injury cases.[7]

The respect accorded the physician-patient relationship in other contexts does not govern the status of the relationship in workers' compensation cases. This is especially true, as discussed earlier, when there is no evidentiary privilege connected with that relationship in Workers' Compensation Law. Thus, these reasons supporting prohibition of such communications are, regardless of their wisdom, no more than policy arguments. Weighing of policy arguments in the administrative law context is within the purview of the legislature, not the courts. The legislature delegated authority to the agency to define policy in this area by promulgating rules regarding physician reporting. ORS 656.252. This court's review of such delegative rules is largely deferential, especially when the agency has special expertise and has made a statutory interpretation at least as plausible as any challenger's. As this court has stated:

> "All legislative decisions involve value judgments of a political nature and so do delegated legislative decisions.
>
> "* * * The delegation of responsibility for policy refinement under such a [policy-delegating] statute is to the agency, not to the court. The discretionary function of the agency is to make the choice and the review function of the court is to see that the agency's decision is within the range of discretion allowed by the more general policy of the statute." *Springfield Education Assn. v. School Dist.*, 290 Or 217, 229, 621 P2d 547 (1980).

See Branscomb v. LCDC, 297 Or 142, 681 P2d 124 (1984) (court will give deference to agency's interpretation of its rule adopted pursuant to a policy-delegating statute).

The Board is permitted, as it did in *Alan W. Hayes, Jr., supra*, to adopt a general policy interpreting one of its rules that will be applicable to future

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[7] Claimants and amicus OTLA cite subsequently withdrawn legal ethics opinions of the Oregon State Bar for the existence of an ethical obligation, e.g., Oregon State Bar, Legal Ethics Opinion No. 248 (Sept 1981). There are no current legal ethics opinions limiting communication between lawyers and physicians. See Oregon Formal Ethics Opinions, v-vi (1991) (all former ethics opinions withdrawn).

We note that the Rules of Conduct adopted by the Oregon State Bar and the Oregon Medical Association limit such communication generally but provide an explicit exception for communication in conformity with Oregon workers' compensation rules. See Rule 3a, Statement of Principles Governing Certain Lawyer-Physician Relationships (1984).

cases. ORS 183.355(2); *Marbet v. Portland Gen. Elect.*, 277 Or 447, 461, 561 P2d 154 (1977). The Board, in its interpretation permitting the communications, relied upon the express policy of the Workers' Compensation Law that seeks to avoid the delay and excessive costs caused by litigation and the adversarial system. ORS 656.012(2)(b); OAR 438-05-035.[8] The Board's interpretation is not inconsistent with this express policy, and it is not our task on judicial review to evaluate these competing interests and substitute our judgment for the judgment of the Board on what policy provisions should prevail; this would be beyond our scope of review. ORS 656.298(6) and 183.482(8)(a).

2. *Type of Communications Contemplated*

Claimant next argues that the workers' compensation statutes and the rules, themselves, do not envision these types of communications. Moreover, claimant asserts that the existence of numerous detailed workers' compensation provisions governing written reports by physicians[9] manifests an intent to make written reports the exclusive mode of communication between an employer's lawyer and a claimant's treating physicians. We find this argument unpersuasive.

ORS 656.252(1) authorizes promulgation of rules regarding physician reporting.[10] Subsection (1) does not refer to "writing," but only to reports. We find no reason to presume a legislative intent to require all reports to be written or to restrict verbal communication between employers or their agents and injured workers' physicians. We note, in fact, that subsection (2) of ORS 656.252 explicitly requires physicians to "advise" insurers and self-insured employers within five days of a worker's anticipated release to return to work or the reopening of a claimant's closed claim and subsection (5) requires physicians to "notify" insurers or self-insured employers within five days of changes in physicians or referrals to new physicians. Nothing in the statute addresses *how* physicians are to report to, advise, or notify insurers or self-insured employers so long as the relay of information is prompt and correct.

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[8] ORS 656.012(2)(b) provides that an objective of the Workers' Compensation Law is:

> "To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable[.]"

OAR 438-05-035 states:

> "BOARD POLICY; LIBERAL CONSTRUCTION. It is the policy of the Board to expedite claim adjudication and amicably dispose of controversies. These rules shall be liberally construed in favor of the injured worker to carry out the remedial and beneficent purposes of the Workers' Compensation Law. The overriding principle is substantial justice. With respect to postponement or continuance of hearings, substantial justice requires consideration of the relative financial hardship of the parties. The unrepresented injured worker shall not be held strictly accountable for failure to comply with these rules. Any individual who undertakes to represent a party in proceedings under these rules shall be required to comply with these rules."

[9] *E.g.*, OAR 436-10-030 (renumbered from OAR 436-69-101 and concerning reporting requirements for medical providers), OAR 436-10-100 (renumbered from OAR 436-69-801 and concerning independent medical examinations), OAR 438-07-005 (regarding presentation of medical evidence at hearings), and OAR 438-07-015 (regarding disclosure of claims information).

Claimant further argues that repeated references to written reports in administrative rules reflect a policy of preventing "unnecessary intrusion into the confidentiality of the physician/patient relationship." This argument, however, also is belied by ORS 656.252(1), which provides that the purpose of the written report requirement is "to insure the prompt and correct reporting and payment of compensation in compensable injuries." The legislative history reveals considerable concern about promptness, but no discussion of protecting claimant confidentiality. *See, e.g.*, Minutes, House Committee on Labor and Management, March 22, 1967, pp 1-3. ORS 656.252 goes on to absolve complying physicians from legal liability for disclosure of medical confidences.[11] We conclude that physician-patient confidentiality was of scant concern to the legislature in this context, especially in the face of competing concerns for promptness and accuracy.

ORS 656.252 is a non-exclusive outline of the types of communications physicians are required to initiate with insurers or self-insured employers. It

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[10] ORS 656.252(1) provides:

> "(1) In order to insure the prompt and correct reporting and payment of compensation in compensable injuries, the director shall make rules governing * * * reports by attending and consulting physicians and other personnel of all medical information relevant to the determination of a claim to the injured worker's representative, the worker's employer, the employer's insurer and the department. *Such rules shall include, but not necessarily be limited to*:
>
> "(a) Requiring attending physicians to make the insurer or self-insured employer a first report of injury within a specified time after the first service rendered.
>
> "(b) Requiring attending physicians to submit follow-up reports within specified time limits or upon the request of an interested party.
>
> "(c) Requiring examining physicians to submit their reports, and to whom, within a specified time.
>
> "(d) Such other reporting requirements as the director may deem necessary to insure that payments of compensation be prompt and that all interested parties be given information necessary to the prompt determination of claims.
>
> "(e) Requiring insurers and self-insured employers to audit billings for all medical services, including hospital services." (Emphasis added.)

[11] ORS 656.252(4) provides:

> "No person who reports medical information to a person referred to in subsection (1) of this section, in accordance with department rules, shall incur any legal liability for the disclosure of such information."

The purpose for this provision was to encourage prompt release of information and to prevent claimants and their legal counsel from using confidentiality concerns to delay or impede the flow of relevant medical information. Exhibit A, Summary of C Engrossed SB 48, May 24, 1979.

is not an outline of any particular or exclusive mode for such communications. Therefore, the Board was free to interpret the statute in its rules to define permissible modes of communication.

The Board, in its opinion in *Allen W. Hayes, Jr., supra*, interpreted the rules consistent with the stated purpose of the written reports. The Board stated:

> "We find nothing in the statutes or rules requiring an insurer to give claimant prior notice of its intent to contact his or her physician. Further, we find such a requirement is inconsistent with our stated policy of full, fair and expeditious disclosure of information between the parties. It is also inconsistent with the legislature's intent to create a compensation system that reduces litigation and minimizes the adversarial process." 37 Van Natta at 1182.

The Board was within its statutory power in so construing the statute.[12]

3. *Lack of Specific Reference*

In essence, claimant argues that the lack of a specific reference to communications of the type involved in this case within the statutes and rules means that such communications are not permitted. The Board takes the opposite view: it interprets the absence of specific references *prohibiting* this type of communication to mean that such communications *are* permitted. Although claimant's interpretation is a plausible one, and may be supported by the policy reasons stated above, the Board's interpretation of the rules also is reasonable and is not inconsistent with the Workers' Compensation Law and rules made pursuant to that law.

CONCLUSION

We do not find the Board's interpretation of the Workers' Compensation Law to be erroneous, ORS 183.482(8)(a), and we defer to the Board's interpretation of its own rules.[13]

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

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[12] We note that the dissent's interpretation of the statute (that a statutory requirement of written reports precludes oral communication between employers and claimants' physicians) might be plausible but for the context of this statute. The workers' compensation system is the antithesis of common-law tort rules regarding recovery for personal injury. All references to common-law sources outside the workers' compensation context are inapposite. The Oregon workers' compensation system was created by this state's legislature to streamline the process by which injured workers could be paid for compensable injuries. *See generally* ORS 656.012. Policy trade-offs were made in this streamlining effort, and it is not for this court to re-weigh competing policies. The legislature did not by statute expressly preclude employer/physician communication and, finding no evidence of legislative intent to do so, we decline to establish a limiting construction.

[13] Claimant also relies on a Washington Supreme Court case, *Loudon v. Mhyre*, 110 Wash 2d 675, 756 P2d 138 (1988), a wrongful death tort claim. In that personal injury case, the court held that pre-hearing communications by defense counsel with the claimant's treating physician were not permitted despite waiver of the physician-patient privilege, thus limiting defense counsel to formal discovery methods.

That case is unpersuasive here due to the different context provided by the Workers' Compensation Law. We express no opinion on the persuasiveness of that case in its own context.

UNIS, J., concurring in part, dissenting in part.

I agree with the majority's analysis of the physician-patient privilege in Part A of the opinion. I also agree with the majority that the fact that the statutes and rules do not provide for the physician-patient privilege in workers' compensation contested cases does not resolve the second question of whether *ex parte* [1] communications between claimant's treating physicians and employer's lawyer are proper. I disagree, however, with the majority's conclusion in Part B of the opinion that the workers' compensation statutes contemplate this type of communication. Therefore, I dissent from Part B of the majority opinion.

On review of the Board's action, this court is to determine whether the agency has "erroneously interpreted a provision of law and that a correct interpretation compels a particular action." ORS 183.482(8)(a); *see* ORS 656.298(6) (review by the Court of Appeals as provided in ORS 183.482(8)). The Board, in its opinion in *Allen W. Hayes, Jr.*, 37 Van Natta 1179, 1182 (1985), stated:

> "We find nothing in the statutes or rules requiring an insurer to give claimant prior notice of its intent to contact his or her physician. Further, we find that such a requirement is inconsistent with our stated policy of full, fair and expeditious disclosure of information between the parties. It is also inconsistent with the legislature's intent to create a compensation system that reduces litigation and minimizes the adversarial process."

I agree with the majority that "[t]he Board is permitted * * * to adopt a general policy interpreting one of its rules that will be applicable to future cases." 312 Or at 473; *see Marbet v. Portland Gen. Elect.*, 277 Or 447, 461, 561 P2d 154 (1977) (discussing usual authority of administrative agencies to promulgate such rules). But "[a]n administrative agency may not, by its rules, amend, alter, enlarge or limit the terms of a statute." *Cook v. Workers' Compensation Dept.*, 306 Or 134, 138, 758 P2d 854 (1988). This court has stated:

> "'*A statute which creates an administrative agency and invests it with its powers restricts it to the powers granted. The agency has no powers except those mentioned in the statute.* It is the statute, not the agency, which directs what shall be done. The statute is not a mere outline of policy which the agency is at liberty to disregard or put into effect according to its own ideas of the public welfare.'" (Emphasis added.)

U. of O. Co-Oper. v. Dept. of Rev., 273 Or 539, 550, 542 P2d 900 (1975) (quoting *Gouge v. David*, 185 Or 437, 459, 202 P2d 489 (1949)). Thus, this court must determine whether the Board's interpretation of its rules in *Alan W. Hayes, Jr.*, *supra*, is consistent with its statutory authority. The Board discussed its authority for its ruling in *Allen W. Hayes, Jr.*:

> "The Oregon Legislature has declared that it is the policy of the Workers' Compensation Law 'to provide a fair and just administrative system * * * that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable.' ORS 656.012(2)(b). Pursuant to this policy, the Board

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[1] The term *ex parte* as used in this opinion means communications with claimant's treating physicians by the employer or its representatives without the consent of claimant or claimant's counsel.

> has promulgated rules of practice and procedure designed to 'expedite claim adjudication and amicably dispose of controversies.' OAR 438-05-035. Among these rules are those pertaining to the generation of documentary evidence."

37 Van Natta at 1182.

ORS 656.012(2)(b), quoted in *Allen W. Hayes, Jr., supra*, sets policy but does not give the Board rulemaking authority. OAR 438-05-035 and the other rules mentioned in *Allen W. Hayes, Jr.*,[2] were promulgated under the authority of ORS 656.726(4).[3] OAR 438-05-005. ORS 656.726(4) provides:

> "The board may make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings * * *."[4]

This statute does not specifically grant authority to the Board to authorize *ex parte* contact with claimant's treating physicians. Another statute, ORS 656.252, does specifically address contacts with physicians. The critical issue, not addressed by the majority, is whether ORS 656.252 in any way limits the Board's authority to establish rules governing contacts with treating physicians under ORS 656.726(4). I conclude that it does.

ORS 656.252(1) authorizes rulemaking governing two things: (1) "audits of medical service bills,"[5] and (2) "reports by attending and consulting physicians and other personnel of all medical information relevant to the determination of a claim." ORS 656.252(1)(a)-(e) specifies certain types of reports which the Board's rules shall govern. Those statutory provisions are prefaced by the qualifying phrase that "[s]uch rules shall include, but not necessarily be limited to [items specified in (1)(a)-(e)]." As the majority suggests, the Board may make rules other than those described in ORS 656.252(1)(a)-(e). 312 Or at __ .

However, this qualifying phrase *does* limit the Board's authority to make rules; the Board is only given authority to make "[s]uch rules" as defined earlier in ORS 656.252(1). That is, the Board may only make rules governing "reports by attending and consulting physicians and other personnel of all medical information relevant to the determination of a claim." Therefore, the statutory authority to make rules governing these "reports by attending and consulting physicians" not only limits the Board's rulemaking authority under ORS 656.252, but it also limits the Board's general rulemaking authority under ORS

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[2] The Board mentioned that OAR 438-07-005(2), 438-07-005(6), and 438-07-015(2) and (3) were consistent with its policy and thus with its decision allowing *ex parte* contact. *Allen W. Hayes, Jr.*, 37 Van Natta 1179, 1182 (1985).

[3] At the time OAR 438-05-035 was promulgated, the subsection was ORS 656.726(5), but the wording was identical to current ORS 656.726(4).

[4] The director is also given a general grant of authority to "[m]ake and declare all rules which are reasonably required in the performance of the director's duties." ORS 656.726(3)(a).

[5] This phrase was added to the statute in 1987. Or Laws 1987, ch 884, 3.

656.726(4) and 656.726(3)(a). This is consistent with *Cook v. Workers' Compensation Dept., supra*; with *U. of O. Co-Oper. v. Dept. of Rev., supra*; and with *Smith v. Clackamas County*, 252 Or 230, 233, 448 P2d 512 (1969), *overruled on other grounds, Whipple v. Howser*, 291 Or 475, 487 n 6, 632 P2d 782 (1981) ("the inclusion of specific matter tends to imply a legislative intent to exclude related matters not mentioned").

A number of factors are helpful in determining what the phrase "reports by attending and consulting physicians and other personnel of all medical information relevant to the determination of a claim" means in the context of ORS 656.252. In the abstract, a report can be either written or oral. This court, therefore, looks to the context of the statute, to the purpose of or policy underlying the statute, and to legislative history. Accordingly, I will proceed in that order.

The context of the statute indicates that the word "reports" refers to "written reports." The reports referred to in ORS 656.252(1)(a)-(c) are described as items which are "submitted" or "made." ORS 656.254(1)[6] provides that the Board "shall establish medical report *forms* [i.e., written] * * * to be used by * * * physicians." (Emphasis added.) Further, ORS 656.252(1) provides that the reports are to be submitted to "the injured worker's representative, the worker's employer, the employer's insurer *and* the department." (Emphasis added.) By using the conjunctive "and," the legislature has specified that the reports are to be submitted to *all* of these groups inclusively, not to any one of them separately. The most plausible mechanism by which this can occur is through written reports; verbal reports could only satisfy this requirement if all parties are represented, as in a deposition-type setting. The conjunctive construction in ORS 656.252(1) indicates that, whether in verbal or written form, *ex parte* contact was not authorized. This is the policy underlying the statute.

In addition, ORS 656.252(4) provides immunity from legal liability when a person "reports medical information to a person referred to in subsection (1) of this section, in accordance with department rules." The only way that a physician can submit a report to "a [singular] person" under ORS 656.252(4) and have it submitted to all four parties in ORS 656.252(1) conjunctively is either for the report to be written so that the exact same report can be distributed to all parties or for all parties to be present if it is to be given verbally.

This reading of the statute is consistent with the policy underlying the statutory framework. The Board supported its determination that *ex parte* contact with physicians was allowed by quoting the language in ORS 656.012(2)(b) that the policy of the workers' compensation law is "[t]o provide a fair and just administrative system [7] * * * that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable." *Allen W. Hayes, Jr., supra*, 37 Van Natta at 1182. The Board, quoting OAR 438-05-035, relied on the notion that the system must be expeditious, and went so far to say that not allowing *ex parte* contact "is inconsistent with [the Board's] policy of full, fair and expeditious disclosure of information." *Allen W. Hayes, Jr., supra*, 37 Van Natta at 1182. However, OAR 438-07-005[8] states that "[t]o avoid unnecessary delay and expense medical evidence should be presented in the form of written reports." Apparently, the Board itself does not consider the use of written reports to be contrary to the legislative policy of

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[6] ORS 656.254 was enacted as part of the same bill that enacted ORS 656.252. Or Laws 1967, ch 626.

expeditious claim adjudication. Neither does the legislature. The purpose of ORS 656.252 is to "insure prompt and correct reporting," and the specific reports described in that section are, as I have shown, to be issued in written form and to be shared mutually.

Legislative history suggests that the word "reports" in ORS 656.252(1) was used to refer to "written reports." Reports were discussed as something to be contained in the file. House Bill 1594, as introduced, stated that the reports "shall be on forms established by the board."[9]

Even the administrative rule promulgated pursuant to ORS 656.252 expressly defines the term "report" as a written document. Division 10 of OAR 436, promulgated in part pursuant to ORS 656.252, OAR 436-10-001(1), defines "report" as "medical information transmitted in written form containing relevant subjective and objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the [Board]." OAR 436-10-003(36). It is interesting that this definition is the result of 1990 amendments, adopted after the Board's decision in *Allen W. Hayes, Jr., supra*.[10] Apparently the Board does not consider the

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[7] I need not address whether allowing ex parte contact is consistent with the policy of providing a fair system.

As the majority points out in Part B(1), 312 Or at 472, claimant and amicus Oregon Trial Lawyers Association pointed to many sources recognizing a special relationship between patient and physician outside the context of the physician-patient evidentiary privilege. For recent discussions about the wisdom of allowing *ex parte* contacts and the treatment of the issue in other jurisdictions, see Annot., *Discovery: Right to Ex Parte Interview With Injured Party's Treating Physician*, 50 ALR4th 714 (1986); Dalgleish, *Woytus and Ex Parte Physician Interviews in Missouri*, 47 J of Mo Bar 265 (June 1991); Dewey, Jr., and Heine, *Survey of Illinois Law - Evidence*, 15 So Ill Un L J 997 (1991); Comment, *Shielding the Plaintiff and Physician: The Prohibition of Ex Parte Contacts with a Plaintiff's Treating Physician*, 13 Campbell L Rev 233 (1991); Note, *Restricting Ex Parte Interviews with Nonparty Treating Physicians: Crist v. Moffatt*, 69 NC L Rev 1381 (1991); and Note, *Professional Ethics Codes in Court: Redefining the Social Contract Between the Public and the Professions*, 25 Ga L Rev 1327 (1991).

[8] OAR 438-07-005 was proposed at the same time as OAR 438-05-035. OAR 438-05-005.

[9] This language was changed to "the director shall establish medical report forms" and was codified in ORS 656.254(1). *See* note 6, *infra*. This change in language arguably could support the idea that, because forms shall be established but not that reports "shall be on forms" as originally proposed, reports need not be written. However, this change in language could just as well support the idea that, while forms are provided, if the physician submits a report in letter format but not on a form, it still is considered a report. Legislative history does not indicate the significance of the change.

[10] The former rule, OAR 436-69-005(21), also promulgated in part to carry out the provisions of ORS 656.252, *former* OAR 436-69-004, defined "report" as "transmittal of medical information in a narrative letter, on a form or in progress notes from the worker's medical file. Reports may be handwritten but all shall be legible and include all relevant or requested information."

legislature's description in ORS 656.252 of specific methods by which to obtain information from physicians to be a limitation on the Board's authority to establish rules regarding obtaining information in other ways. I disagree.

ORS 656.252 specifies how the Board is to obtain information from physicians. ORS 656.252(1) limits the Board's authority to promulgate rules for obtaining information to those methods consistent with ORS 656.252(1), absent a specific statutory authorization providing the authority for other methods. ORS 656.252(1) could reasonably be interpreted to allow either (1) rules regarding only written reports, or (2) rules regarding written reports and verbal reports in the presence of the injured worker's representative, the worker's employer, the employer's insurer, and the department, but not to allow *ex parte* contact.

I would hold that the Board's ruling in *Allen W. Hayes, Jr., supra*, that allows *ex parte* contact with the physicians as a part of the process of obtaining the reports was an erroneous interpretation of law and, therefore, that reliance on *Allen W. Hayes, Jr., supra*, for that proposition in the present case also was error.[11]

Because it is clear from the record that the seven exhibits, which consisted of letters describing claimant's condition from three of claimant's treating physicians, resulted from ex parte communications by the employer's lawyer with these physicians, I would reverse the decision of the Court of Appeals and remand this case to the Board to address, in the first instance, the appropriate consequences of the Board's use of evidence obtained as a result of the improper *ex parte* contact.

Fadeley, J., joins in this opinion.

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[11] Because I would hold that the Board's rule allowing *ex parte* contact was without statutory authority as required for immunity under ORS 656.252(4), it might follow (subject to the issue concerning, *inter alia*, reasonable reliance) that the rule would not provide the physician immunity for participating in ex parte contact. In the absence of this immunity, *Humphers v. First Interstate Bank*, 298 Or 706, 696 P2d 527 (1985), recognizes the existence of tort liability for the breach of a confidential relationship. *See also* ORS 677.190, which provides:

> "The Board of Medical Examiners for the State of Oregon may refuse to grant, or may suspend or revoke a license to practice issued under this chapter for any of the following reasons:
>
> "* * * * *
>
> "(5) Willfully or negligently divulging a professional secret."

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