VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 41

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A compilation of the decisions of the Oregon Workers' Compensation Board and the opinions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law.

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CITE AS

41 Van Natta ____ (1989)

DONNA E. ASCHBACHER, Claimant
Doblie & Associates, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 88-07257
October 3, 1989
Order Denying Reconsideration

The insurer requests reconsideration of our July 13, 1989 Order on Review that reversed a Referee's order which upheld the insurer's denial of claimant's occupational disease claim for a low back condition. Subsequently, the insurer filed its first request for reconsideration. On August 10, 1989, we issued an Order Denying Reconsideration.

On August 14, 1989, the insurer filed its petition for judicial review of our July 13, 1989 order with the Court of Appeals. See ORS 656.298(3). Thus, jurisdiction to consider this matter vested with the Court of Appeals upon the filing of the insurer's appeal. See Pedro G. Alcala, 39 Van Natta 1161 (1987). The insurer's second request for reconsideration was mailed on September 13, 1989.

It is possible to withdraw and reconsider an order after the filing of a petition for judicial review with the Court of Appeals. ORS 183.482(6); Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Under these circumstances, we decline to withdraw our July 13, 1989 Order on Review. 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), rev den 300 Or 605 (1986).

IT IS SO ORDERED.

BETTY J. CURTISS, Claimant
Richard Nesting, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

Own Motion 88-0312M
October 3, 1989
Order Postponing Action on Own Motion

On June 28, 1988, Referee Borchers postponed litigation in WCB Case No. 88-04967 pending own motion closure of claimant's 1979 injury claim. The postponed litigation concerns permanent disability ratings under determination orders issued in the 1979 claim. These determination orders were issued before the expiration of claimant's aggravation rights in March 1985. Claimant now asks the Board to take whatever action is necessary to allow the pending litigation to go forward.

Claimant's 1979 injury claim is currently in open status pursuant to the self-insured employer's voluntary reopening in April 1987. Aggravation rights on the claim expired in March 1985. By Own Motion Order, issued June 24, 1988, the Board found claimant medically stationary as of November 2, 1987 and terminated temporary disability compensation as of that date. The Board deferred rating permanent disability because of the pending litigation in WCB Case No. 88-04967.

After reviewing this matter, we again conclude that the litigation in WCB Case No. 88-04967 should go forward without further action from the Board at this time. Where a claim is reopened after expiration of aggravation rights, but while litigation is pending on

a determination order issued within the aggravation period, the claimant is entitled to closure under ORS 656.268. Carter v. SAIF, 52 Or App 1027 (1981); Coombs v. SAIF, 39 Or App 293 (1979).

Accordingly, WCB Case No. 88-04967 should proceed to hearing. The Referee should rate permanent disability based on claimant's condition at the time of hearing if she is medically stationary at that time. Pauline Travis, 37 Van Natta 194 (1985); Jeffrey Barnett, 36 Van Natta 1636 (1984). If claimant is not medically stationary at the time of hearing, the Referee should rate permanent disability as of the date claimant was last medically stationary. Pauline Travis, supra.

We request that the Referee provide the Board with a copy of the order in WCB Case No. 88-04967. Subsequent to issuance of the Referee's order, the Board will consider whether any further action on the own motion matter is required.

IT IS SO ORDERED.

GENE R. HARREL, Claimant
Pozzi, et al., Claimant's Attorneys

Own Motion 89-0112M
October 3, 1989
Own Motion Order

The self-insured employer has submitted to the Board claimant's claim for an alleged worsening of his October 29, 1981, industrial injury. Claimant's aggravation rights have expired. The employer has accepted responsibility for claimant's surgery, but opposes reopening of his claim for temporary disability benefits on the basis that claimant has withdrawn 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). After review of the record, we conclude that claimant has sustained such a worsening.

Nevertheless, to receive temporary disability benefits, claimant must be in the work force at the time of the worsening. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). The record here shows that claimant has not worked since December, 1987. Consequently, claimant can prevail only by proving that he is willing to work and that either: (1) he is making reasonable efforts to obtain employment; or (2) reasonable efforts to obtain employment would be futile because of a compensable injury. See Dawkins v. Pacific Motor Trucking, supra.

The parties previously went to hearing on another issue relating to claimant's compensable injury. In an Opinion and Order issued July 1, 1988, the Referee found that claimant would have continued to work beyond his then-current age of 62 but for the disabling effects of his compensable injury and its sequela. Additionally, the record shows that claimant returned to light work in November, 1988, but quit shortly thereafter due to increasing pain. Following our review of this record, we find that claimant is willing to work and that reasonable efforts to find work would be futile due to his compensable injury and its sequela. We find, therefore, that claimant was in the work force at the time of his worsening.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence March 2, 1989, the date he was hospitalized for surgery, and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

FLOYD D. MAUGH, Claimant

Own Motion 89-0462M
October 3, 1989
Own Motion Order

The self-insured employer has submitted to the Board claimant's claim for an alleged worsening of his October 3, 1975 right knee injury. Claimant's aggravation rights have expired. The self-insured employer has accepted responsibility for the proposed surgery. It now recommends that claimant's claim not be reopened under our own motion authority, alleging that claimant is currently receiving temporary disability compensation at the maximum rate under a separate claim with the employer. In the alternative, the employer recommends that claimant's temporary disability benefits be prorated between the two claims.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability benefits commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, his claim is reopened for temporary disability compensation to commence the date he is hospitalized for surgery, and to continue until his right knee injury becomes medically stationary or he returns to regular work at his regular wage, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the 1975 injury claim should be closed by the insurer pursuant to OAR 438-12-055.

Pursuant to our Own Motion Order, issued March 20, 1989, claimant is receiving temporary disability benefits under a separate 1979 left knee injury with the employer. (WCB Case No. 89-0137M). Claimant is not entitled to receive double the statutory sum for the same period of time loss because he has two separate disabling injuries. 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). The employer is free to petition the Compliance Division for a pro rata distribution of payments between the two claims. See OAR 436-60-020(2).

IT IS SO ORDERED.

PAUL R. MILLER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 87-07092
October 3, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Melum's order that set aside its partial denial of claimant's neck and back conditions. Claimant cross-requests review of that portion of the order which affirmed a Determination Order that awarded 5 percent (6.75 degrees) scheduled permanent disability for loss of use of the left foot. Claimant did not file a brief on review. We affirm with regard to the partial denial issue. Accordingly, the extent of permanent disability question is premature.

ISSUES

(1) Compensability of claimant's neck and back conditions.

(2) Extent of scheduled permanent disability.

FINDINGS OF FACT

The Board adopts the Referee's Findings.

FINDINGS OF ULTIMATE FACT

The injury to claimant's left foot materially contributed to claimant's back and neck conditions requiring medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's opinion on the compensability issue with the following comment.

On review, the insurer argues that claimant has failed to sustain his burden of proof on either an industrial injury theory or an occupational disease theory. However, occupational disease has never been an issue in this case. Rather, claimant contends that his back and neck conditions were caused by the injury of October 6, 1986. The fact that claimant's neck and back symptoms became apparent gradually following the October 1986 injury does not convert a claim for those conditions into one for occupational disease.

On the merits, we are convinced that a chain of causation has been established between the October 6, 1986 injury and the onset of claimant's neck and back symptoms. In this regard, the factors listed by the Referee establish that the injury to claimant's left foot directly and materially contributed to his neck and back conditions. See Florence v. SAIF, 55 Or App 467 (1982); Jose L. Altamirano, 41 Van Natta 389, 392 (1989).

We turn next to the issue of the extent of claimant's permanent disability. In this regard, claims are not to be closed, and extent of permanent disability determined, until the workers' condition has become medically stationary. ORS 656.268(1). The evidence does not establish that claimant's neck

and back conditions are medically stationary. Consequently, the Determination Order award of permanent disability is premature. Accordingly, the claim will be remanded to the insurer for acceptance and processing of claimant's neck and back condition. At such time as claimant's compensable conditions become medically stationary, the claim shall be closed pursuant to ORS 656.268.

Claimant has successfully defended against a carrier-initiated request for review attempting to disallow his compensation. Claimant's attorney would normally be entitled to an assessed fee for his services on Board review. See ORS 656.382(2). However, claimant did not file a brief. Moreover, there is no evidence in the record that claimant's counsel provided legal representation short of briefing which would support an attorney fee award on review. See Dan W. Hendrick, 38 Van Natta 208 (1986), aff'd mem 83 Or App 275 (1987). We conclude that claimant's counsel is not entitled to the award of an assessed fee on review. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated November 25, 1987 is affirmed in part and reversed in part. Those portions of the Referee's order that upheld the insurer's denial of claimant's psychological condition and that set aside the insurer's partial denial of claimant's neck and back condition are affirmed. The neck and back claims are remanded to the insurer for acceptance and processing in accordance with law. That portion of the Referee's order that affirmed the September 14, 1987 Determination Order is reversed. The Determination Order is set aside as premature. A client-paid fee, not to exceed $155, is approved.

TERRY L. REYNOLDS, Claimant	WCB 87-12734
Ackerman, et al., Claimant's Attorneys	October 3, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of Referee Huffman's order that set aside its denial of claimant's occupational disease claim relating to his low back. We reverse in part.

The Board adopts the Referee's findings of fact and conclusions of law with the following additions and alterations.

FINDINGS OF FACT

Spondylolysis is an abnormal separation in the pedicle of a vertebra. Spondylolisthesis is the forward displacement of one vertebra upon another. Claimant's spondylolysis and spondylolisthesis preexisted his employment and were not pathologically worsened by his work activity. The spinal instability associated with the conditions, however, did materially contribute to the cause of claimant's lumbar disc disease and chronic lumbosacral strain and continues to materially contribute to the symptoms associated with those conditions.

CONCLUSIONS OF LAW

Because claimant's spondylolysis and spondylolisthesis

were not pathologically worsened by his work activity, they are not compensable. Weller v. Union Carbide Corp., 288 Or 27, 35 (1979). The adverse effects of the instability associated with the conditions on claimant's lumbar disc disease and chronic lumbosacral strain, however, are compensable. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Barbara J. Meherin, 41 Van Natta 772 (April 7, 1989).

ORDER

The Referee's order dated January 15, 1988, as clarified in the Order on Reconsideration dated March 18, 1988, is reversed in part. That portion of the Referee's order that held claimant's spondylolysis and spondylolisthesis compensable is reversed. The remainder of the Referee's order is affirmed. For services on review concerning claimant's successful defense of a portion of the Referee's order, claimant's attorney is awarded $500, to be paid by the self-insured employer. A client-paid fee of up to $1,236 is approved.

MARGARETTE I. SCHAFFER-WRIGHT, Claimant — WCB 86-13929
Martin J. McKeown, Claimant's Attorney — October 3, 1989
Cummins, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of that portion of Referee Hettle's order which set aside its partial denial of claimant's bilateral foot condition. On review, the sole issue is compensability.

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

Although we agree with the Referee's conclusion that the employer's denial was improper under Bauman v. SAIF, 295 Or 788 (1983), we also find that claimant's current bilateral foot condition is compensable on its merits.

Dr. Arbeene, claimant's treating physician, has followed claimant since the original claim. He has documented chronic bilateral foot pain which he diagnosed as plantar facsitis. Dr. Rosenbaum felt that claimant's symptoms could be due to a small fiber neuropathy or myelopathy, but also conceded that he could not rule out the coexistence of a plantar fascitis. Drs. Lafrance and Hahn have diagnosed probable tarsal tunnel syndrome, but based this diagnosis on claimant's symptoms as the nerve conduction studies proved inconclusive.

We find Dr. Arbeene's opinion persuasive. He has treated claimant since the original claim and has consistently opined that her condition is caused by plantar facsitis. In making this finding, we note that Dr. Arbeene concurred with Dr. Rosenbaum's report, by "checking the box." We do not take this to mean, however, that he was retracting his prior opinions. Further, Dr. Rosenbaum indicated that he could not rule out the coexistence of plantar fascitis. Under these circumstances, Dr. Arbeene's well-reasoned opinion is entitled to greater weight. Weiland v. SAIF, 64 Or App 810, 814 (1983).

We conclude that claimant's current bilateral foot condition is causally related to her original accepted claim. In making this finding we note that plantar facsitis is the only diagnosis that a majority of the physicians in the record endorse. Dr. Rosenbaum's suggestion that claimant's symptoms could be due to a fiber neuropathy, despite the lack of objective neurological findings, does not rise to the level of medical probability. Further, the diagnosis of tarsal tunnel syndrome is also not supported by objective findings. In light of this, we conclude that claimant's current bilateral foot condition is compensable regardless of whether the current condition is diagnosed as plantar fascitis, tarsal tunnel syndrome, or fiber neuropathy. See Karen M. Partridge, 39 Van Natta 137 (1987).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated December 2, 1987, is affirmed. A client-paid fee, not to exceed $1,607.50, is approved.

JOANNE L. SEELIG, Claimant
Roll, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 87-11468
October 3, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Podnar's order that upheld the insurer's denial of her occupational disease claim for an alleged allergy to shrimp and crab. We affirm.

ISSUE

The compensability of claimant's alleged allergy to shrimp and crab.

FINDINGS OF FACT

Claimant began working for the employer, a seafood cannery, in June 1985. Before working for the employer, she had worked for other employers in the seafood industry for approximately 30 years, primarily as a "crab shaker." For the employer, she worked as a shrimp weigher and crab shaker.

In December 1986, claimant developed a number of symptoms including a sore throat, headaches, itchy eyes and visual disturbances, earaches, nasal congestion, chest tightness, and coughing. She sought treatment from Dr. Linehan, her family doctor, in early 1987. In February 1987, claimant requested a referral to an allegy specialist and Dr. Linehan sent her to Dr. Hastings, a Longview, Washington allergist. Dr. Hastings

performed intradermal tests which revealed strong reactions to the pollens of a number of trees, grasses and weeds and to molds, house dust and animal dander. He also performed skin scratch tests which revealed significant reactions to egg and clam and strong reactions to crab and shrimp. He diagnosed allergic rhinitis and conjunctivitis, prescribed a series of allergy shots and recommended that claimant avoid exposure to crab or shrimp. Claimant left work as a result of this recommendation.

In May 1987, claimant was examined by Dr. Montanaro, an Assistant Professor of Medicine in the Allegy and Clinical Immunology Department of the Oregon Health Sciences University. Dr. Montanaro ordered blood serum and skin scratch allergy tests which showed only mild reactions to house dust and mite extract. Reactions to pollens, animal dander, molds, crab and shrimp were negative. Montanaro opined that claimant had experienced an acute upper respiratory infection and sinusitis in late 1986 and early 1987 rather than an allergic reaction. On July 10, 1987, the insurer issued a denial of claimant's occupational disease claim for the alleged allergy to crab and shrimp.

In September 1987, Dr. Huffman, a Longview, Washington ear, nose and throat specialist, ordered additional blood serum allergy tests. These tests revealed mild reactions to crab and shrimp. In a subsequent report, Huffman noted that the serum tests he ordered had been graded by different procedures than those ordered by Dr. Montanaro and indicated that the results of the two sets of tests might actually be the same, only graded differently. Dr. Montanaro later opined that the grading system which had been used for his tests was more widely accepted in the medical community than that used for Dr. Huffman's tests and otherwise questioned the accuracy of Dr. Huffman's tests.

FINDINGS OF ULTIMATE FACT

Claimant is not allergic to crab or shrimp. She experienced an acute upper respiratory infection and sinusitis in late 1986 and early 1987 rather than an allergic reaction to crab or shrimp.

CONCLUSIONS OF LAW

To establish the compensability of her alleged allergy to crab and shrimp, claimant has the burden of proving that her work activity or exposure with the employer was the major contributing cause of such an allergy. Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983).

There are four medical opinions in the present case concerning the nature of claimant's condition in late 1986 and early 1987. Dr. Hastings opined that claimant had experienced an allegic reaction to the crab and shrimp which she encountered in the employer's cannery. Dr. Linehan summarily concurred in this opinion. Dr. Huffman opined that claimant had a mild allergy to crab and shrimp, but offered no opinion regarding its cause or of the cause of claimant's symptoms in late 1986 and early 1987. Dr. Montanaro opined that claimant was not allergic to crab or shrimp and that she had experienced an acute upper respiratory infection and sinusitis rather than an allergic reaction.

In assessing the persuasiveness of the above medical opinions, we examine three basic factors: the source of the

opinion, its factual basis and its logical force. Earl M. Brown, 41 Van Natta 287,291 (February 17, 1989). The source of the opinion has reference to the expertise and objectivity of the one giving it. See Abbott v. SAIF, 45 Or App 657, 661 (1980). The factual basis of the opinion relates to the completeness and correctness of the information upon which it is based. See Somers v. SAIF, 77 Or App 259, 263 (1986). The logical force of the opinion concerns the depth, clarity and cogency of the analysis. See id.

Of the four doctors who rendered opinions in this case, Dr. Montanaro appears to have the most expertise in the field of allergies. He is an instructor in that field and was expressly recognized by Dr. Hastings as "a very well trained and well respected allergist [with] considerable experience in the field of work-place allergies." (Ex. 21-1). Dr. Hastings is an allergy specialist, but his expertise as such is not otherwise reflected in the record. Dr. Linehan is a family practitioner and his expertise in the filed of allergies is not reflected in the record. In view of the fact that he referred claimant to Dr. Hastings for an evaluation of her potential allergies, however, his expertise does not appear to be great. Dr. Huffman is an ear, nose and throat specialist. His expertise in the field of allergies is not reflected in the record.

Evaluation of the factual bases of the various opinions in this case is problematic. Dr. Hastings, Dr. Montanaro and Dr. Huffman all ordered different tests and based their opinions only upon their own tests. Drs. Huffman and Montanaro agreed, however, that the serum tests they employed are generally more accurate than the intradermal and scratch tests employed by Dr. Hastings. (See Ex. 24-1; 29-10). Dr. Montanaro also asserted that the grading system which he used for his serum tests was more widely accepted in the medical community than that used for Dr. Huffman's tests and otherwise questioned the accuracy of Dr. Huffman's tests. (Ex. 28-1). Dr. Huffman did not respond to these remarks. In view of Dr. Montanaro's apparently superior expertise in the field of allergies and Dr. Huffman's failure to respond to Dr. Montanaro's criticisms of his tests, we accept the results of the tests ordered by Dr. Montanaro as accurate. The factual basis of Dr. Montanaro's opinion, therefore, is correct. The factual bases of the opinions of Drs. Hastings, Linehan and Huffman are not.

Regarding the logical force of the opinions, Dr. Montanaro's opinion is well-reasoned and is the most thoroughly explained.

In view of the above analysis, Dr. Montanaro's opinion is worthy of the greatest deference and we accept it over those of Drs. Hastings, Linehan and Huffman. Dr. Montanaro opined that claimant did not have an allergy to crab or shrimp and that her symptoms in late 1986 and early 1987 were due to an acute upper respiratory infection and sinusitis. Because claimant does not have an allergy to crab or shrimp, her occupational disease claim for such an allergy must fail. There is no evidence which would support the conclusion that claimant's work activity was the major contributing cause of her acute upper respiratory infection and sinusitis. We conclude, therefore, that claimant has failed to prove a compensable occupational disease.

ORDER

The Referee's order dated February 29, 1988 is affirmed. A client-paid fee of up to $751.50 is approved.

CRAIG M. TOLONEN, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Rankin, VavRosky, et al., Defense Attorneys

WCB 88-01320
October 3, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of that portion of Referee Knapp's order which set aside its denial of claimant's "ongoing" need for medical services for an anxiety/stress condition. Although claimant has not formally cross-requested review, his attorney seeks a greater attorney fee than that awarded by the Referee.

The Board affirms the order of the Referee, but for different reasons.

ISSUES

1. The compensability of claimant's current anxiety/stress condition and resulting need for medical services.

2. Whether the insurer's denial is an impermissible prospective denial of claimant's medical services.

3. Whether claimant's attorney is entitled to a greater attorney fee than that awarded by the Referee, for services rendered at the hearing.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

In June, 1987, the parties went to hearing before a prior Referee, Referee Menashe. The issue before the prior Referee was whether claimant's anxiety/stress condition was a compensable occupational disease. Drs. Larsen and Turco, the employer's consulting physicians, testified that claimant's condition was not work related. In finding that claimant had proven compensability, the Referee was not persuaded by the conclusions of either Larsen or Turco. We affirmed the prior Referee's order on March 22, 1989. See Craig M. Tolonen, 41 Van Natta 347 (1989).

CONCLUSIONS OF LAW

The Merits

Claimant must prove that his compensable occupational disease of January, 1987, is a material contributing cause of his current anxiety/stress condition and resulting need for medical services. See ORS 656.245(1).

In November, 1987, claimant was reexamined by Drs. Larsen and Turco, at the request of the employer. As before,

they opined that claimant's anxiety/stress condition was the result of non-industrial factors. First, Larsen stated, inter alia:

> "I certainly believe that [claimant's] on-going complaints are not materially related to his employment but are directly related to his personality structure, his use of alcohol and now his use of Benzodiazepine tranquilizers."

One week later, Turco reported, inter alia:

> "This man's symptoms have not changed since my last examination even though he has been working the shift that he wishes to. As you know, I did not feel that his difficulties were related to the work experience but felt his problems in that regard were primarily of an administrative nature. This man has had long-standing hysterical symptoms associated with long-standing psychological problems. The current diagnosis is hysterical conversion reaction as it was previously in an individual with chronic alcoholism by history." (Emphasis added).

In January, 1988, the employer issued a denial of all further medical treatment in association with claimant's anxiety/stress condition.

The following month, Ms. Price, nurse practitioner, reported, inter alia:

> "I am treating [claimant] for stress symptoms which I feel are exacerbated by his work conditions. His symptoms are better, and he is slowly discontinuing his medicine. However, he continues to live under the threat of shift change."

Claimant's supervisor, Mr. Sanders, testified that he had no immediate plans to change claimant to swing shift. He conceded, however, that his plans could change if the employer prevailed in its appeal of claimant's anxiety/stress claim. Tr. 19 and 21.

Claimant testified that after receiving the insurer's denial of January, 1988, his anxiety/stress symptoms increased. He experienced anxiety attacks, numbness, and impaired breathing. He wished to continue biofeedback treatments, until his level of medication was further reduced.

We are not persuaded by the opinions of Drs. Larsen and Turco. They have consistently opined that claimant's anxiety/stress condition is due to non-industrial factors. While Larsen and Turco are entitled to reiterate their earlier opinions, their views conflict with the law of the case. Kuhn v. SAIF, 73 Or App 768, 771-72 (1985). That is, claimant has a compensable anxiety/stress condition, as a matter of law. We see little, if anything, in the opinion of Larsen or Turco to suggest a new or

superseding non-industrial cause since the prior Referee's order of June, 1987.

Moreover, claimant credibly testified that his biofeedback treatments were helping to reduce his symptoms. His symptoms resurfaced, however, when the employer issued its denial of January, 1988. In addition, Ms. Price reported that claimant's symptoms were exacerbated by the threat that he could be reassigned to swing shift. On cross-examination, Mr. Sanders conceded that claimant could be transferred back to swing shift if the compensability of his anxiety/stress condition is overturned on appeal.

In sum, we are persuaded by the lay testimony and the medical opinion of Ms. Price that claimant's compensable anxiety/stress condition remains a material contributing cause of his current anxiety/stress condition and resulting need for medical services.

Prospective Denial

The employer's denial of January, 1988, states, inter alia:

> "Based on medical information, it appears that your ongoing symptoms and complaints are no longer related to your claim of January 15, 1987 or your employment activities. Therefore, ongoing medical treatment in association with anxiety symptoms and complaints are respectfully denied. This is only a partial denial of your claim and does not impair or change the status of your claim since the Opinion [and] Order."

The Referee interpreted the denial narrowly as applying only to "then-current and not subsequent medical services." We disagree.

The denial plainly denies "ongoing" medical services; not merely "current" medical services. A prospective denial that attempts to deny a worker's right to all future or ongoing medical services, as here, is impermissible. Danny M. Rusk, 41 Van Natta 358 (1989); see ORS 656.245(1).

Accordingly, independent of our above analysis on the merits, we set aside the employer's denial on the additional grounds that it impermissibly denied claimant's right to future medical services.

Attorney Fee

The Referee awarded claimant's attorney an assessed fee of $1,100 for setting aside its January, 1988, denial. Claimant's attorney asserts that his services at the hearing entitle him to a fee of $1,650.

After considering the factors set forth in OAR 438-15-010(6), we conclude that a $1,100 assessed fee appropriately compensated claimant's attorney for his time and effort expended at the hearing.

Lastly, claimant's attorney is entitled to an additional assessed fee for his services on Board review concerning the denial issue. However, inasmuch as no statement of services has been received from claimant's attorney, we cannot award such a fee. OAR 438-15-010(5).

ORDER

The Referee's order, dated April 14, 1988, is affirmed. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $918.50.

EDWARD WALTERS, Claimant	WCB 87-16006
Vick & Gutzler, Claimant's Attorneys	October 3, 1989
Beers, Zimmerman & Rice, Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Bethlahmy's order that set aside its partial denial of claimant's chiropractic services.

The Board reverses the order of the Referee.

ISSUE

Whether claimant was entitled to continuing chiropractic services after he had formally changed attending physicians and his new physician neither referred him to a chiropractor nor recommended chiropractic services.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Claimant signed two Change of Attending Physician forms. The first in September, 1986, and the second in April, 1987. On each form, directly above claimant's signature, the following statement is conspicuously provided:

"WORKER'S STATEMENT

I wish to change attending physician.
The insurer may notify my previous attending physician."

There is no showing of fraud, misrepresentation, duress, or lack of mental capacity at the time claimant signed each form.

CONCLUSIONS OF LAW

The parties do not dispute the application of OAR 436-10-060(2) to this case. That rule provides, inter alia:

> "The patient may have only one attending physician at a time. Treatment by other physicians shall be at the request of the attending physician who shall promptly notify the insurer of the request. * * *."

Here, claimant compensably injured his left knee in 1978. He treated with Dr. Tongue, an orthopedist, for several years. In

September, 1986, he signed a Change of Attending Physician form, which specified Dr. Beebe, a chiropractor, as his new attending physician. While continuing to treat with Beebe, he signed a second Change of Attending Physician form in April, 1987. This second form specified Dr. Rusch, M.D., as his new attending physician. Rusch never referred claimant to Beebe nor recommended that he obtain chiropractic treatment.

In October, 1987, the insurer issued a partial denial of claimant's chiropractic treatment since April, 1987. The basis for the insurer's denial was that Dr. Beebe's services had not been requested by Dr. Rusch, as required by OAR 436-10-060(2).

Finding that claimant had not intended to change physicians in April, 1987, the Referee set aside the insurer's partial denial. We disagree.

Claimant formally changed attending physicians from Dr. Beebe to Dr. Rusch in April, 1987. In so doing, he executed a Change of Attending Physician form. As we found above, that form conspicuously provided that claimant wished to change attending physicians. There is no evidence that he did not understand the plain and unambiguous language directly above his signature. Nor is there any evidence of fraud, misrepresentation, or duress. Accordingly, claimant testified, inter alia:

> "Q. And that form says -- well, let me take a look at it directly here. It says, 'I wish to change attending physician.' Why did you sign that form?"
>
> "A. I was under the impression that I had to sign that to get [the insurer] to pay for [Dr. Rusch's] services."
>
> "Q. What led you to think that?"
>
> "A. I didn't really understand the rules as I'm starting to learn them. I thought that I had to sign that for him to receive the money from [the insurer]."

Under such circumstances, we conclude that claimant changed his attending physician from Dr. Beebe to Dr. Rusch in April, 1987. Claimant's mistaken belief as to the legal effect of that form, no matter how genuine, is not controlling. See Alva P. Hogan, 40 Van Natta 565 (1988). Inasmuch as Rusch never requested Beebe to treat claimant, claimant's treatment by Beebe after April, 1987, was not compensable. OAR 436-10-060(2).

ORDER

The Referee's order, dated March 8, 1988, is reversed. The insurer's partial denial is reinstated and upheld.

JOHN W. WHARTON, Claimant
Vick & Gutzler, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 88-06680
October 3, 1989
Order of Dismissal

The SAIF Corporation moves for dismissal of claimant's request for review of a Referee's order on the ground that claimant did not request review. The motion is granted.

FINDINGS

Claimant requested a hearing concerning an April 27, 1988 Determination Order. The hearing was scheduled for June 29, 1988. On that date, claimant did not appear at the hearing. SAIF moved for dismissal of the hearing. On July 7, 1988, the Referee dismissed the hearing request without prejudice. The order contained a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On July 18, 1988, the Hearings Division received a letter from claimant. The letter, dated July 12, 1988, was addressed to the Referee. The letter began as follows: "[i]n answer to your letter, dated July 7, 1988, and our telephone conversation, today, July 12, 1988 . . ." After explaining that he believed his hearing had been cancelled, claimant concluded as follows: "I think you'd better check your records before writing such letters as the one I received today (the Order of Dismissal)." The letter, which was neither mailed by registered nor certified mail, indicated that copies had been mailed to SAIF and its insured.

On June 28, 1989, claimant contacted the Board concerning the status of his case. On June 30, 1989, the Board mailed a computer-generated letter to the parties acknowledging a request for review of the Referee's July 7, 1988 order.

ULTIMATE FINDINGS

Claimant did not request Board review of the Referee's July 7, 1988 dismissal order.

CONCLUSIONS

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

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to clearly identify a document as a party's request for Board review of a Referee's order. Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

In Gordon, the claimant mailed a letter to the Board some 21 days after a Referee's dismissal order. In her letter, claimant stated that she "had no intentions of stopping [her] case" and would "not stop this until [she got] a fair settlement." Inasmuch as the letter was received shortly after the Referee's order and reflected the claimant's desire to continue the prosecution of her case, we held that it constituted a request for Board review.

The present case is distinguishable from Gordon. Here, as in Gordon, claimant's letter, which was received shortly after the Referee's order, did not expressly request Board review. However, unlike Gordon, claimant's intentions are far from clear and unmistakable. In fact, there appears to be only one certainty. That is, in direct response to the Referee's order and a recent "telephone conversation", claimant specifically addressed his July 12, 1988 letter to the Referee, rather than the Board.

Considering such circumstances, including claimant's express admonishments to the Referee to "check your records", we interpret the July 12, 1988 letter to be, in effect, a request for reconsideration of the Referee's dismissal order. See June M. Hejduk, 41 Van Natta 887 (1989) (Motion to set aside Referee's dismissal order does not constitute request for Board review); Myron A. Schmidt, 41 Van Natta 896 (1989) (Motion to vacate Referee's dismissal order is not a request for Board review). Consequently, we hold that claimant did not request Board review of the Referee's order. ORS 656.295(1); Rochelle M. Gordon, supra; Gerardo V. Soto, supra.

Inasmuch as the Referee's order has not been appealed, stayed, withdrawn, modified, or republished within 30 days of its issuance, it has become final by operation of law. ORS 656.289(3); Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986); International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

HAYWARD A. CLARK, Claimant
Ackerman, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 85-12381, 86-12353, 86-12901 & 86-15739
October 5, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of that portion of Referee Seymour's order which set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

From August 1978 until almost December 1979, claimant was employed as a panel patcher. Most of the work on that job involved using a hand router, putty gun, and glue gun on the patch line. Claimant is right-handed and held the router and guns in his right hand. There were many grasping motions involved.

In November 1979, claimant began experiencing numbness, mostly at night, in his right hand and wrist. The symptoms worsened and claimant filed a claim for the condition on January 22, 1980, which was accepted by the employer. The 801 form noted that the condition involved nerves in the right wrist. The condition was diagnosed as right carpal tunnel syndrome. A subsequent 827 form filed January 29, 1980 diagnosed claimant's condition as: probable carpal tunnel syndrome of the right arm; probable early carpal tunnel syndrome of the left, secondary to job exposure.

In May 1986, claimant was examined by Dr. Mundall, neurologist, at the request of Dr. Thomas, claimant's treating chiropractor. Dr. Mundall reported that in addition to low back pain, claimant had mild symptomatic carpal tunnel syndrome, right worse than left. Claimant filed an 801 form for bilateral carpal tunnel syndrome which was dated April 23, 1986.

In August 1986, the employer denied claimant's claim for bilateral carpal tunnel syndrome.

FINDINGS OF ULTIMATE FACT

Claimant's work activities were the major cause of his bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW

The employer contends that the Referee should have admitted a rebuttal report from Dr. Nathan that was obtained after the hearing. We note that the Referee specifically left the record open for the deposition of Dr. Mundall and a deposition of claimant. As the record was not left open for any further evidence, other than the depositions mentioned above, we agree that Dr. Nathan's rebuttal report should not have been admitted. See former OAR 438-06-090. Accordingly, we have not considered the report. We now proceed to the merits.

The Referee concluded that claimant's bilateral carpal tunnel syndrome is causally related to his work activities. We agree.

In order to prevail on an occupational disease claim, claimant must show that the work activity either caused the condition or, in the case of a preexisting condition, that the work activities caused a worsening of the underlying condition. Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). This requires claimant to prove that the work activities were the major contributing cause of the condition or its worsening. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985).

The issue of whether claimant's work activities were the

major contributing cause of his bilateral carpal tunnel syndrome 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 record. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Mundall, who is treating claimant's bilateral carpal tunnel syndrome, opined that the condition was work-related. His opinion is based on the nature of claimant's work activities, i.e. frequent gripping activities and because claimant's symptoms fluctuated depending on what kind of work he was doing at the time. Dr. Cuttler agreed with Dr. Mundall and opined that claimant's work activity was consistent with a work-related condition. Further, Dr. Golden also felt that the bilateral carpal tunnel syndrome was work-related.

Only Dr. Nathan felt that claimant's work was not causally related to his bilateral carpal tunnel syndrome. He considered it unlikely that the type of work activities performed by claimant would be responsible for the development of the condition.

Following our de novo review of the medical and lay evidence, we conclude that claimant's work activities were the major cause of his bilateral carpal tunnel syndrome. In reaching this conclusion, we are persuaded by the well-reasoned opinions of Drs. Mundall and Cuttler. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, claimant's bilateral carpal tunnel syndrome condition is compensable.

Although claimant prevailed before the Board on an employer-initiated request for review, he submitted no brief for our consideration. Further, there is no other evidence that claimant's counsel meaningfully participated on Board review. Accordingly, we find that claimant's counsel is not entitled to a fee in this forum. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated August 14, 1987 is affirmed. A client-paid fee, not to exceed $359, is approved.

HAROLD L. DAVENPORT, Claimant
Becker & Hunt, Claimant's Attorneys
Nelson, et al., Defense Attorneys

Own Motion 87-0120M
October 5, 1989
Own Motion Determination

The insurer voluntarily reopened claimant's claim for a worsened condition related to his industrial injury of October 31, 1979. The claim has now been submitted for closure. We grant claimant permanent total disability and additional temporary total disability benefits.

ISSUES

1. Extent of claimant's permanent disability, including permanent total disability.

2. Temporary total disability.

FINDINGS OF FACT

Claimant, a maintenance mechanic/combination welder, sustained various compensable injuries on October 31, 1979, when he slipped and fell from a ladder, landing on his right side. X-rays that night revealed several fractured right ribs. The next day, claimant sought treatment for pain in his chest, neck, right shoulder and elbow. He was taken off work for a few weeks and treated conservatively. The claim was closed by Determination Order on March 25, 1980, with no permanent disability award.

Claimant continued to have pain in the neck and right shoulder, along with tenderness and occasional swelling of the right elbow. In early 1981, claimant sought treatment for what was diagnosed as right olecranon (elbow) bursitis. The elbow was sucessfully aspirated, eliminating further swelling. Claimant was also diagnosed with a right shoulder sprain, which was treated conservatively. The claim was again closed by Determination Order on October 28, 1982, with awards of 10 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of use or function of the right arm.

In February, 1984, claimant began treating with Dr. Manley, an orthopedist. Claimant complained of acute tenderness and numbness radiating into the fingers of his right hand. Nerve conduction studies revealed right tardy ulnar nerve palsy.
Meanwhile, in December, 1984, claimant's neck pain increased in severity, occasionally shooting into the right shoulder. X-rays revealed significant cervical spondylosis. In February, 1985, the employer closed down the plant where claimant had been working as a maintenance mechanic. Claimant has not worked since then.

On May 28, 1985, due to worsening ulnar neuropathy, claimant underwent surgical transposition and decompression of the right ulnar nerve. He responded well to surgery, though some residual symptoms of numbness and tingling remained. The insurer reopened claimant's claim and began paying temporary disability benefits beginning on the date of surgery.

Claimant continued to have pain along the neck and right shoulder. Dr. Manley diagnosed biceps tendonitis and prescribed physical therapy. Nevertheless, by January, 1986, claimant had constant neck and right shoulder pain, along with residual symptoms in the right hand. Various diagnostic studies on the cervical spine in March, 1986, revealed significant spondylosis with evidence of significant potential for nerve root compression. However, surgery was not recommended for that condition. In 1987 claimant experienced a worsening of the right shoulder and hand conditions. Also, it was determined that oral medication for the right shoulder was irritating claimant's stomach. Treatment by injections and physical therapy appeared to help.

Claimant presently has permanent physical limitations due to the effects of his compensable injuries, which limit him to very sedentary work. He has significant loss of right shoulder motion and experiences shoulder impingement with any type of abduction or flexion. There is also significant muscular tenderness and a 20-percent loss of strength in the right shoulder when compared to the left shoulder. He cannot climb ladders, crawl, reach with his right arm above shoulder level, or perform

other activities requiring significant shoulder weight-bearing or shoulder stabilization. Claimant also has tremors and lack of grip strength in his dominant right hand. He can lift no more than seven pounds with the right hand, whereas he can lift 20 pounds with the left hand.

Claimant is 59 years of age and has a GED. He has prior work experience as a maintenance mechanic, combination welder, lead welder, boilermaker, pipe fitter/welder and farmer. However, he is unable to return to those occupations due to his compensable injuries. Claimant was referred for vocational evaluation in January, 1989. His vocational counselor contacted over 50 employers to investigate the possibility of employment as a printing press operator, color stripper, or machine operator. Although several "hands on" training possibilities were located, only one employer was willing to consider an on-site evaluation. That employer reported a press operator position requiring occasional lifting of 25-30 pounds and expressed interest in hiring claimant through an on-the-job training program, provided claimant demonstrated sufficient capacities and aptitudes to perform the job. However, there is no indication that claimant has yet entered an authorized training program.

FINDING OF ULTIMATE FACT

Claimant became medically stationary as of March 21, 1989. Due to the permanent effects of his compensable injuries, claimant is unable to perform any work at a gainful and suitable occupation. He has made reasonable efforts to find work.

CONCLUSIONS OF LAW AND OPINION

To be entitled to permanent total disability benefits, claimant must prove that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Dr. Manley, claimant's treating physician, indicated that claimant can perform very sedentary work. Because claimant is capable of working, he can prevail only by proving that he falls within the so-called "odd-lot" doctrine. Under that doctrine, an injured worker, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Because the injured worker has some capacity for employment, he is statutorily required to make reasonable efforts to find work, although he need not engage in job seeking activities that would be futile. ORS 656.206(3); Welch v. Bannister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

The vocational evidence establishes that claimant is not physically capable of returning to work in any of his previous occupations. Furthermore, Dr. Manley, the treating physician, opines that claimant is unable to return to any type of work due to his age and physical limitations, though he released claimant for proposed on-the-job training as a machine operator, stating that it is "[c]ertainly worth a try." Claimant's vocational counselor located several training possibilities, including one employer who expressed interest in hiring claimant as a press

operator, provided that claimant demonstrated sufficient capacities and aptitudes to perform the job. However, there is no indication in the record that a specific training program has yet been developed for claimant.

Whether claimant is permanently and totally disabled must be decided on the basis of conditions existing at the time of the decision, not on his potential for future employment after retraining. Gettman v. SAIF, 289 Or 609, 614 (1980); Welch v. Banister Pipeline, supra. Therefore, we decline to consider whether claimant may be employable after proposed retraining. Instead, we assess claimant's employability based on conditions existing at this time. We do not find that claimant presently has the transferable skills necessary to find work within his physical limitations, despite his reasonable efforts to obtain work through vocational rehabilitation services. Accordingly, claimant is awarded permanent total disability benefits.

A permanent total disability award under the odd-lot doctrine is effective as of the earliest date that all relevant medical, social and vocational elements exist to support the award. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, mod 53 Or App 863, 867 (1981). Here, we find that all of the elements supporting claimant's award existed on March 21, 1989, when Dr. Manley declared claimant medically stationary. Accordingly, claimant's permanent total disability award is effective as of March 21, 1989.

Finally, claimant is awarded temporary total disability from May 28, 1985, through March 21, 1989, the medically stationary date. Deduction of overpaid temporary disability from unpaid permanent disability is approved.

IT IS SO ORDERED.

SYLVIA J. MINSHULL, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Kevin L. Mannix, Defense Attorney
Rankin, et al., Defense Attorneys

WCB 87-07146 & 87-03289
October 5, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

D. G. Shelter Products ("D. G."), a self-insured employer, requests review of that portion of Referee Daron's order that set aside its denial of claimant's "new injury" claim for cervical, shoulder and left arm conditions. In his respondent's brief, claimant argues that we should affirm the Referee's decision with regard to D. G. Alternatively, claimant contends that we should reverse that portion of the Referee's decision to uphold the aggravation and medical services denial relating to the same condition issued by Norpac Foods, Inc. ("Norpac"), a self-insured employer. For its part, Norpac contends that the Board lacks jurisdiction to review the Referee's decision to uphold its denial because that issue has not been properly raised before the Board. We affirm.

ISSUES

1. Jurisdiction.

2. Whether D. G. is precluded from denying responsibility for claimant's current condition.

3. If not, then compensability of and responsibility for claimant's current condition.

FINDINGS OF FACT

Claimant sustained a compensable injury to her neck, shoulders, arms and low back on November 3, 1982, while working for Norpac's predecessor in interest, Stayton Canning Co. A myelogram disclosed discogenic disease at C5-6, with amputation of the right C6 nerve root. Dr. Brett, neurosurgeon, subsequently reported that claimant could benefit from surgery. The employer denied the proposed surgery.

A January 29, 1986 Determination Order granted 40 percent unscheduled permanent partial disability resulting from claimant's November 3, 1982 injury.

Claimant requested a hearing on, among other things, the surgery denial and the permanent disability award. By Referee's order dated June 6, 1986, the surgery denial was upheld and the unscheduled permanent disability award was reduced from 40 percent to 10 percent.

During 1985 and 1986, claimant worked briefly for two separate employers as a cook. Claimant received periodic chiropractic treatments from Dr. Saboe.

In October 1986, claimant commenced work for D.G. Claimant's employment duties involved light work.

On February 20, 1987, Norpac issued a denial of ongoing chiropractic treatment as not reasonable or necessary and no longer related to the November 3, 1982 injury.

On March 3, 1987, claimant was seen by her family physician, Dr. Hartmann. The following day, Dr. Hartmann contacted Norpac by letter indicating that claimant's condition resulting from her November 3, 1982 injury had never resolved and that claimant's C5-6 disc problem could be surgically corrected. Dr. Hartmann requested that the claim be reopened.

On about March 15, 1987, claimant was transferred at D.G. from light work to heavier work.

On March 18, 1987, while pulling some moulding, claimant experienced the sudden onset of pain in the left shoulder and neck. Claimant also experienced radiating pain into the left forearm and dysesthesia into the fingers of the left hand.

On March 20, 1987, claimant filed an injury claim with D.G.

On April 9, 1987, Norpac denied Dr. Hartmann's request for reopening.

A CT scan was performed at the request of Dr. Brett on April 13, 1987. That scan disclosed bulging discs at C5-6 and C6-7, most pronounced at C5-6 centrally and to the right. A myelogram performed on the same day also disclosed defects at the C5-6 and C6-7 levels.

On April 29, 1987, Dr. Brett performed anterior cervical diskectomy and fusion at the C5-6 and C6-7 levels. Claimant subsequently experienced a significant reduction in her symptoms on both the left and right. Claimant successfully returned to light work 6 weeks following surgery.

On May 5, 1987, D. G. denied responsibility for claimant's claim on the basis that her current medical condition was not attributable to her employment with D. G.

On May 27, 1987, Norpac objected to the issuance of an ORS 656.307 order on the basis of compensability.

On June 12, 1987, D. G. issued a letter amending its prior denial letter. The new letter stated, in part:

> "Based on additional records we have now received, we deny the compensability of your current cervical, shoulder and left arm conditions. It is our position that you suffered only a minor strain in your shoulder, neck and left arm while employed by us. This has fully resolved and required no further medical attention. ***"

The letter did not advise claimant whether the accepted "minor strain" was considered disabling or nondisabling; nor did it inform claimant of her aggravation rights or the right to contest the characterization of a claim as nondisabling at a hearing. The letter did advise claimant of her hearing rights concerning the denial.

Claimant requested hearings on Norpac's February 20, 1987 denial of chiropractic treatment, Norpac's April 9, 1987 aggravation and medical services denial, D. G.'s May 5, 1987 denial, and D. G.'s June 12, 1987 denial. A consolidated hearing was held on October 5, 1987.

The Referee upheld Norpac's denials, while setting aside D. G.'s denials and remanding the claim to D. G. for acceptance and processing, including reimbursement for the expenses of Dr. Brett's April 1987 surgery.

D. G. requested Board review of the Referee's order. The request listed both the Board case number relating to the claim against D. G. and the case number relating to the claim against Norpac.

FINDING OF ULTIMATE FACT

Claimant's March 18, 1987 work incident while employed by D. G. independently contributed to a worsening of claimant's cervical condition. This worsening took the form of additional tearing of the annulus.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Norpac argues that the Board is without jurisdication to consider any issues arising out of WCB Case No. 87-03289 relating

to its aggravation and medical service denials. Norpac contends that D. G.'s request for review dealt only with those issues decided against D. G. in WCB Case No. 87-07416. Norpac asserts that no request for review was filed in WCB No. 87-03289.

We find, however, that Norpac is wrong both factually and legally. Factually, the request for review filed by D. G. captioned both WCB Case numbers. Legally, no party may, by the terms of its request for review, limit the Board's jurisdiction to a portion of an order directed to a particular case number. William E. Wood, 40 Van Natta 999, 1001 (1988). While parties are encouraged to focus their arguments on specific issues present in an appealed Referee's order, the parties cannot limit the scope of the Board's de novo review by requesting review of only select case numbers which are included with other case numbers in the same Referee's order. Id.; see also Kenneth Privatsky, 38 Van Natta 1015 (1986) (Board has authority to consider a respondent's contentions notwithstanding its failure to cross-request review).

We conclude that our review authority extends to all issues decided by the Referee's order.

Compensability and Responsibility

The Referee found that there was insufficient evidence to support the compensability of claimant's claims against either employer. However, he went on to find that, because D. G. conceded that a compensable incident had occurred on March 18, 1987, it was precluded from denying the compensability of claimant's then-current cervical, shoulder and left arm conditions.

On review, D. G. notes that the only condition accepted in its June 12, 1987 letter was a resolved shoulder, neck and left arm strain. D. G. contends that the Supreme Court's decision in Johnson v. Spectra Physics, 303 Or 49 (1987), is controlling; that pursuant to that decision, it is not precluded from issuing a partial denial of claimant's current shoulder, neck and left arm conditions.

We conclude, however, that the Court's decision in Johnson v. Spectra Physics is not controlling here. The issue in Johnson was whether, under Bauman v. SAIF, 295 Or 788 (1983), the insurer's acceptance of a claim for a back injury precluded the insurer from subsequently denying a carpal tunnel syndrome condition which was part of the same claim. The Court concluded that, in the absence of a specific acceptance of the carpal tunnel condition, the insurer was not precluded from denying the same. The Court found that such a "partial denial" is appropriate when "two or more injuries or conditions are separate aspects of the same claim." Id. at 58.

Here, by contrast, D. G. is not denying a separable condition, but instead is arguing that the condition has resolved. D. G.'s denial is an attempt, in effect, to both accept the claim as a temporary condition and to deny any permanency to the claim. Thus, D. G.'s June 12, 1987 letter amounts to a preclosure denial of the claim. As such, it is impermissible. Roller v. Weyerhaeuser Co., 67 Or App 583, 586 (1984). Instead, the proper procedure for D. G. to follow would be to accept the claim and, if the evidence indicates the accepted condition has resolved, to submit the claim for closure. D. G.'s attempt to terminate future responsibility before the extent of claimant's disability has been determined is, therefore, invalid.

Alternatively, we find that claimant has sustained her burden of proving that the March 18, 1987 work incident while employed by D. G. independently contributed to a worsening of her underlying condition. See Hensel Phelps Const. v. Mirich, 81 Or App 290, 294 (1986). We note in this regard that even a slight worsening is sufficient so long as the worsened condition results in disability or requires medical services. Mission Insurance Co. v. Dundon, 86 Or App 470, 473 (1987).

Dr. Brett reported that the March 18, 1987 incident contributed to further tearing of the annulus. Dr. Brett treated claimant following both the November 1982 incident and the March 1987 incident. He performed surgery following the March 1987 incident. His lengthy experience with claimant's condition, both before and after the most recent injury, entitles his opinion to considerable persuasive weight. Weiland v. SAIF, 64 Or App 810 (1983).

D. G. argues that we should not accept Dr. Brett's opinion because it is based upon an inaccurate history. D. G. contends in this regard that Dr. Brett relied upon a history of sudden onset of left extremity symptoms on March 18, 1987. D. G. asserts that claimant was experiencing left extremity symptoms shortly before the March 18, 1987 incident. Our review of the record discloses that claimant was complaining of left shoulder discomfort shortly before the March incident. However, following the March incident claimant complained of pain extending to the left forearm and tingling into the fingers of the left hand. Claimant was not reporting such symptoms immediately prior to the March 18, 1987 incident. We conclude that the history relied upon by Dr. Brett of sudden onset of left extremity complaints was not inaccurate.

Dr. Raaf, neurosurgeon, opined that the March 18, 1987 incident did not "significantly" contribute to claimant's condition. D. G. argues that we should accept the opinion of Dr. Raaf over that of Dr. Brett. We decline to do so. As noted above, we do not find that the history relied upon by Dr. Brett was inaccurate. Further, Dr. Raaf examined claimant only once. Moreover, Dr. Raaf's failure to find that the March 1987 incident "significantly" contributed to claimant's condition is not dispositive. As noted earlier, even a slight independent contribution operates to shift responsibility to a latter employer if the worsened condition results in disability or requires medical treatment.

Here, the worsened condition resulted both in disability and a need for medical services. Claimant was disabled from work for several days commencing March 20, 1987. Shortly thereafter, Dr. Brett performed surgery. Although Dr. Brett had recommended surgery prior to this time, the additional tearing of the annulus prompted him to proceed with the surgery. Under the circumstances, we conclude that claimant's worsened condition required medical treatment which itself resulted in temporary disability.

In sum, we agree with the Referee's conclusion that D. G. is precluded from denying responsibility for claimant's condition at hearing. However, even assuming that D. G. is not so precluded, we find on the merits that claimant has sustained her burden of proving a compensable condition for which D. G. is responsible.

ORDER

The Referee's order dated January 8, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $1,072.50, to be paid by D. G. Shelter Products. The Board approves a client-paid fee, not to exceed $1,000, to be paid by D. G. to its counsel. The Board also approves a client-paid fee, not to exceed $657.50, to be paid by Norpac Foods, Inc. to its counsel.

RAYMOND L. POWELL, Claimant	WCB 86-15274
Michael B. Dye, Claimant's Attorney	October 5, 1989
Meyers & Terrall, Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Seymour's order which set aside its denial of claimant's occupational disease claim for an ulcer condition. Claimant cross-requests review, contending that the Referee erred in declining to direct the insurer to pay for a deposition which the insurer had requested, but claimant had offered as evidence at the hearing. On review, the issues are compensability, and responsibility for payment of transcription costs. 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.

At the close of the hearing, the Referee expressly left the record open to allow the insurer's counsel to depose claimant's treating physician, Dr. Lonigan. He stated that after receipt of the deposition, and submission of closing arguments, the record would be closed.

Dr. Lonigan was deposed on September 30, 1987. Thereafter, the insurer's counsel decided not to order a transcript of Dr. Lonigan's testimony. Claimant's counsel wrote the Referee in October 1987, requesting that the Referee enter an order directing the insurer to obtain a transcript of Dr. Lonigan's deposition for submission into the record. By letter dated October 16, 1987, the Referee declined to order the insurer to produce the transcript. On October 27, 1987, claimant's counsel submitted the deposition of Dr. Lonigan, with his closing argument. After receiving the insurer's closing argument, the Referee closed the record.

FINDINGS OF ULTIMATE FACT

Claimant's exposure to stress at work was the major cause of his ulcer condition.

CONCLUSIONS OF LAW

We adopt the conclusions of law, regarding compensability, as set forth in the Referee's order with the following supplementation.

Claimant's ulcer condition is a claim for an occupational disease. Former ORS 656.802(1)(a). In order to

prevail on an occupational disease claim, claimant must show that the work activity either caused the condition, or in the case of a preexisting condition, that the work activities caused a worsening of the underlying condition. Weller v. Union Carbide, 288 Or 27 (1979); Christenson v. SAIF, 73 Or App 119 (1986). This requires claimant to prove that the work activities were the major contributing cause of the condition or its worsening. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985).

Dr. Lonigan opined that the stress exposure associated with claimant's work was the major contributing cause of claimant's development of a duodenal ulcer. There is no evidence to the contrary. Accordingly, we agree with the Referee that the condition is compensable.

In regard to claimant's cross-request concerning payment of transcription costs, we agree that the insurer should be responsible for payment of those costs. After submission of the deposition, the Referee stated that he would close the record and permit closing arguments. The Referee left the record open expressly for the purpose of permitting the insurer to obtain the deposition of Dr. Lonigan, at the request of the insurer's counsel. (Tr. 113). After deposing Dr. Lonigan, the insurer's counsel decided not to have the deposition transcribed. Claimant's counsel, although protesting, had the deposition transcribed and submitted it to the Referee. Closing arguments were received and the record was closed.

We find that the depostion of Dr. Lonigan was requested by the insurer and primarily for its benefit. cf. Senters v. SAIF, 91 Or App 704 (1988). Further, the record was specifically left open by the Referee until the receipt of the deposition and closing arguments. Under these circumstances, we conclude that the insurer is reponsible for payment of the transcription.

ORDER

The Referee's order dated December 3, 1987, is affirmed in part and reversed in part. The insurer is directed to reimburse claimant's counsel for the transcription costs of Dr. Lonigan's deposition. The remainder of the Referee's order is affirmed. For services rendered on review in regard to the compensability issue, claimant's attorney is awarded a reasonable assessed fee of $600. A client-paid fee, not to exceed $1,402.50, is approved.

ROBIN L. PRATT, Claimant	WCB 87-07609
Vick & Gutzler, Claimant's Attorneys	October 5, 1989
Schwabe, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Leahy's order which: (1) affirmed a Determination Order award of temporary partial disability benefits from April 8, 1986 through January 7, 1987; and (2) declined to assess penalties and related attorney fees for alleged unreasonable claims processing. On review, claimant contends that she is entitled to temporary total disability benefits, penalties and related attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable back injury in January 1986. On March 14, 1986, the insurer forwarded a description of a modified job to Dr. Cichoke, claimant's attending physician, and asked whether claimant was capable of performing such a job. On March 17, 1986, the employer mailed claimant a letter which offered her the modified position. Claimant, however, did not receive the employer's offer.

On April 4, 1986, Dr. Cichoke sent claimant's vocational provider a physical capacities form and indicated that judgment would be made in 2 to 3 months as to when claimant would be released to perform work within the limitation described by the physical capacities form. On April 11, 1986, Dr. Chicoke responded to the insurer's letter of March 14, 1986, noting that claimant did not feel she could perform the tasks described in the modified job offer. Claimant became aware of the employment offer through conversation with Dr. Cichoke.

On May 1, 1986, the insurer informed claimant that it was reducing her temporary total disability benefits to temporary partial disability benefits on the basis that she had not responded to the modified job offer. On May 5, 1986, claimant's vocational assistance ended due to the failure to respond to the modified job offer.

A Determination Order issued in May 1987, which awarded claimant temporary total disability from January 31, 1986 through April 7, 1986 and temporary partial disability from April 8, 1986 through January 7, 1987. The Determination Order further awarded claimant 10 percent unscheduled permanent disability.

FINDINGS OF ULTIMATE FACT

Claimant's attending physician did not approve the modified job offered by the employer.

Although claimant was aware of the offered employment, she was not provided with a written offer from the employer.

The insurer's reduction of claimant's temporary total disability benefits to temporary partial disability benefits was unreasonable.

CONCLUSIONS OF LAW

The Referee found that the employer had complied with the provisions of OAR 436-60-030 and therefore its reduction of claimant's temporary total disability to temporary partial disability was proper. We disagree.

OAR 436-60-030(5) allows an employer/insurer to reduce payment of temporary total disability benefits to temporary partial disability benefits when an injured worker refuses wage earning employment prior to claim closure if the following conditions are met. First, the attending physician must be notified by the employer/insurer of the specific duties and requirements of the employment. Second, the attending physician must agree that the offered employment appears to be within the worker's capabilities. Lastly, the employer/insurer must provide

claimant with a written offer of the employment which states the beginning time, date and place, duration of the job, wage rate, an accurate description of the job duties and that the attending physician has said the offered job appears to be within the worker's capability.

In construing this provision, the Court of Appeals has held that an employer/insurer must strictly comply with its requirements before reduction of temporary disability benefits is proper. See Eastman v. Georgia Pacific, 79 Or App 610 (1986).

In this case, Dr. Cichoke was notified by the insurer of the modified job offer on March 14, 1986. On April 4, 1986, he completed a physical capacities form for claimant's vocational provider, but expressly noted that judgment would be made after 2 to 3 months as to when he would release claimant to work within the limitations he prescribed. On April 11, 1986, he replied to the insurer's notification by stating that claimant did not feel she was able to perform any of the described tasks listed.

Although Dr. Cichoke's replies to the vocational provider and the insurer are equivocal, they cannot be interpreted as an agreement that claimant could perform the modified work. We conclude therefore, that the insurer failed to comply with that portion of OAR 436-60-010(5) that requires the attending physician to agree that claimant could perform the modified work. Accordingly, the reduction of claimant's temporary total disability benefits to temporary partial disability benefits was not proper. Eastman, supra.

Alternatively, we also find that claimant had not been "provided with a written offer of employment" as that phrase is used in OAR 436-60-030(5)(c). The employer's supervisor testified that to the best of her knowledge, one of her subordinates had mailed the employment offer. She did not mail it herself. Claimant testifed that she did not receive the written offer, but learned of it through conversation with Dr. Cichoke and subsequent contact with the employer.

Under these circumstances, we conclude that claimant's awareness of the offer is not adequate to satisfy OAR 436-60-010(5)(c) which requires that a written offer be provided to claimant. Accordingly, the employer's reduction of temporary total disability benefits to temporary partial benefits is also improper on this basis.

As we have found the insurer's action improper, the next issue becomes whether it was unreasonable. We conclude that it was unreasonable.

Dr. Cichoke was sent a letter and physical capacities form by claimant's vocational provider in April 1986. The letter requested Dr. Cichoke to fill out a physical capacities form in reference to what limitations would be imposed upon claimant's future work. The letter then asked when claimant would be released to work within those limitations, to which Dr Cichoke indicated that judgment would be made after 2 to 3 months. The only other communcation from Dr. Cichoke in the record is an April 1986 letter to the insurer. In that letter, Dr. Chicoke indicated that claimant did not feel that she could perform the modified work, which was the only reference to the offered employment.

We find that under these circumstances, the insurer did not have a reasonable basis for believing that Dr. Cichoke had agreed that the proposed employment appeared to be within claimant's capabilities. Further, the insurer offers no explanation for failing to obtain Dr. Cichoke's assent prior to reducing claimant's temporary disability benefits. Accordingly, a 25 percent penalty and related attorney fee are warranted.

ORDER

The Referee's order dated November 23, 1987 is reversed. The Determination Order, dated May 4, 1987, is modified. Claimant is awarded temporary total disability benefits from April 8, 1986 through January 7, 1987. The insurer may offset the previously paid temporary partial disability for the same period against this award. Claimant's counsel is awarded 25 percent of the temporary total disability benefits awarded by this order, not to exceed $3,000. This attorney award shall not be subject to the offset. The insurer is assessed a penalty equal to 25 percent of the increased temporary disability benefits created by this order. Claimant's counsel is awarded a reasonable assessed fee of $500, for services at hearing and on review in regard to the penalty issue, to be paid by the insurer. A client-paid fee, not to exceed $629.50, is approved.

SHEILA J. WARNACK, Claimant
Bennett, et al., Claimant's Attorneys

Own Motion 89-0465M
October 5, 1989
Own Motion Order on Reconsideration

Claimant requests reconsideration of the Board's September 6, 1989, Own Motion Order which reopened claimant's claim for temporary disability benefits to commence July 11, 1989, the date of her surgery. Claimant contends that temporary disability benefits should commence June 5, 1989, the date she was hospitalized for treatment. Additionally, she seeks an attorney fee, payable out of compensation, for her attorney's services in this matter.

Under ORS 656.278(1)(a), we may exercise our "own motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. On June 5, 1989, claimant was hospitalized for conservative treatment of her acute back pain; treatment consisted of physical therapy and dietary consultation. We find that claimant's compensable injury has worsened requiring hospitalization for treatment on June 5, 1989. Accordingly, claimant's claim is reopened with temporary disability benefits to commence June 5, 1989, and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier.

In our original order, we declined to approve a fee for claimant's attorney for lack of an attorney retainer agreement. See OAR 438-15-010(1). Claimant now submits an attorney retainer agreement dated November 21, 1988, explaining that it was not previously filed with the Board because her attorney was unaware of the own motion proceeding. She adds that a copy of the agreement was filed earlier with the Hearings Division in connection with her request for hearing.

The filing of an attorney retainer agreement in connection with a hearing request does not excuse the obligation to file a separate copy of the agreement in connection with the Board's own motion authority. Consequently, we regard the current retainer agreement as new evidence. New evidence submitted with a request for reconsideration will be considered only if: (1) the record, without the additional evidence, has been improperly, incompletely or otherwise insufficiently developed; and (2) the additional evidence was unobtainable with due diligence by the moving party prior to its submission to the Board. OAR 438-12-065(3). We find that the attorney retainer agreement was obtainable with due diligance prior to issuance of our original order. Claimant's attorney received a copy of the employer's recommendation to reopen his client's claim. The recommendation was clearly addressed to the Board's Own Motion Division. Hence, we are not persuaded that claimant's attorney was unaware of the own motion proceeding. We decline to consider the attorney retainer agreement and, therefore, deny that portion of claimant's request for reconsideration.

Accordingly, our September 6, 1989, Own Motion Order is abated and withdrawn. As amended herein, we adhere to and republish our September 6, 1989 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

OTTO W. WIRTH, Claimant — WCB 87-08668
Black, Chapman & Webber, Claimant's Attorneys — October 5, 1989
Nelson, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Borchers' order which found that the Hearings Division lacked jurisdiction to enforce a Disputed Claims Settlement.

The Board reverses the order of the Referee.

ISSUES

1. Whether the Hearings Division has jurisdiction to enforce a Disputed Claims Settlement.

2. Whether the insurer violated the terms of the settlement.

3. Whether the assessment of a penalty and attorney fee is appropriate.

FINDINGS OF FACT

Claimant was involved in an on-the-job motor vehicle accident in October, 1983. He apparently suffered no physical injuries, however, and neither missed any work nor sought immediate medical attention.

In January, 1984, claimant began to experience symptoms associated with cerebrovascular insufficiency. He was hospitalized on two occasions. Hospital physicians diagnosed his condition as a hysterical conversion reaction.

Claimant filed an industrial injury claim in February, 1984, which was timely denied by the insurer.

In December, 1984, claimant and the insurer entered into a Disputed Claims Settlement ("DCS"). The settlement stated, inter alia:

> "1. Claimant agrees to accept the sum of $5,000.00 in settlement of the issue of the compensability of this claim. Claimant's attorney shall be entitled to receive 25% of this sum as and for a reasonable attorney fee;
> "2. [The insurer] agrees to indemnify claimant in an amount not to exceed $3,000.00 against the refusal of his private health care carrier to provide him coverage for the medical expenses associated with his hospitalizations of January and February of 1984 on the grounds that they should have been paid by the workers' compensation carrier and against a requirement by his private benefit provider that he reimburse any sums previously paid as benefits associated with his hospitalizations and time loss in January and February of 1984. Respondent's duty to indemnify extends only to the payment of money and is activiated [sic] only by a final, unappealable order of a court or arbitrator.
> "3. [The insurer's] duty to indemnify does not extend to sums rejected by the private health care provider for any reason other than the reason that those sums should have been covered by claimant's workers' compensation carrier and is limited to $3,000.00. Any sums in excess of $3,000.00 are solely the responsibilty of claimant.
>
> "* * * * *.
>
> "4. The parties agree to cooperate with each other fully in any arbitration or court proceeding that may arise out of the refusal by the private health care carrier to pay billings or an attempt by the private health care carrier to secure reimbursement of benefits previously paid." (Emphasis added).

Two months later, claimant's private health carrier sent a letter to the insurer requesting reimbursement in the amount of $3000, pursuant to the DCS. In response, the insurer sent a letter, dated April 26, 1985, stating, inter alia:

> "As stipulated between the parties, our obligation to indemnify [claimant] for medical expenses incurred is activated only

> by a final, unappealable order of an arbitrator or court. Consequently, we must respectfully decline to make the reimbursement requested."

On May 15, 1985, the private health carrier's attorney sent a demand letter to claimant's attorney. That letter requested reimbursement from claimant in the amount of $5,888.10. Claimant's attorney promptly forwarded a copy of the private health carrier's letter to the insurer's attorney and advised him to deal directly with the private health carrier to resolve the reimbursement dispute. The insurer's attorney responded, by letter of June 18, 1985, that the insurer would not provide reimbursement, unless compelled to do so by an arbitrator under ORS 656.289.

On April 8, 1986, claimant's attorney sent a letter to the insurer, stating, inter alia:

> "We would hereby request that you reimburse the [private health carrier] pursuant to our agreement which is based upon the Disputed Claims Settlement with you dated December 6, 1984.
>
> "Please respond to this request within thirty (30) days of the date hereof. Failure to do so may result in the filing of litigation against you without prior notice."

The insurer's attorney promptly responded, by letter of April 14, 1986, that:

> "[F]actors constituting preconditions to our duty to pay have not been met. We therefore perceive no duty to proceed further at this time. More specifically, we will not be reimbursing the [private health carrier] as you requested."

In December, 1986, the private health carrier filed a law suit in federal court naming claimant as the sole defendant. The suit sought the following relief: (1) reimbursement for the payment of medical and temporary disability benefits in the amount of $5,544.95; (2) attorney fees; and (3) costs.

In order to minimize his liability, claimant filed a Confession of Judgment in federal court agreeing to pay his private health carrier $5,500. Before the judgment was entered, claimant's attorney sent a copy of the judgment to the insurer's attorney requesting his comments. By letter of May 6, 1987, the insurer's attorney responded, inter alia:

> "It is our position the Disputed Claim Stipulation imposes on the parties a mutual duty to cooperate in resisting any efforts at recovery claimant's private health carrier might make. By stipulating to judgment against himself and in favor of the [private health carrier], your client

> has not only failed to cooperate with us in resisting their efforts, but has in fact joined forces with them. Consequently, we will resist any efforts [claimant] may make to enforce the Stipulation on the basis of his Stipulated Judgment."

The Confession of Judgment was entered on May 22, 1987.

On June 3, 1987, claimant filed a request for hearing to, inter alia, enforce the terms of the DCS.

ULTIMATE FINDINGS

The DCS required mutual cooperation between claimant and the insurer in any arbitration or court proceeding undertaken by claimant's private health carrier to secure reimbursement of previously paid benefits.

Claimant, through his attorney, initially attempted to fully cooperate with the insurer. After unsuccessful attempts to obtain reimbursement from the insurer pursuant to the DCS, claimant entered into a Confession of Judgment with his private health carrier.

The insurer violated the terms of the DCS by not cooperating with claimant before, during, and after the court proceeding commenced by his private health carrier.

CONCLUSIONS OF LAW

Jurisdiction

The Referee declined to reach the merits of this case, reasoning that the Hearings Division lacked jurisdiction to enforce the DCS. Specifically, the Referee found that inasmuch as claimant had "traded in" her claim for a DCS, there was no "matter[] concerning a claim" under ORS 656.708(3), in which to vest jurisdiction in the Hearings Division.

After the Referee's order, the Court of Appeals held that a DCS constitutes a "claim" sufficient to vest jurisdiction in the Hearings Division. Howard v. Liberty Northwest Ins., 94 Or App 283 (1988). Concluding that the Hearings Division had jurisdiction to enforce a DCS, the Howard court stated:

> "Although the solution is not free from doubt, we conclude that, because the [DCS] resolved a dispute involving a worker's right to receive compensation, which was resolved, as it must have been, within the workers' compensation system by an agreement which the Board had jurisdiction to approve or disapprove, the Board has jurisdiction to supervise its enforcement. Accordingly, claimant is entitled to a hearing on any question concerning it. ORS 656.283." (Emphasis added).

94 Or App at 286-87; see also EBI Companies v. Moore, 90 Or App 99, 102 (1988).

by a final, unappealable order of an arbitrator or court. Consequently, we must respectfully decline to make the reimbursement requested."

On May 15, 1985, the private health carrier's attorney sent a demand letter to claimant's attorney. That letter requested reimbursement from claimant in the amount of $5,888.10. Claimant's attorney promptly forwarded a copy of the private health carrier's letter to the insurer's attorney and advised him to deal directly with the private health carrier to resolve the reimbursement dispute. The insurer's attorney responded, by letter of June 18, 1985, that the insurer would not provide reimbursement, unless compelled to do so by an arbitrator under ORS 656.289.

On April 8, 1986, claimant's attorney sent a letter to the insurer, stating, inter alia:

> "We would hereby request that you reimburse the [private health carrier] pursuant to our agreement which is based upon the Disputed Claims Settlement with you dated December 6, 1984.
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> "Please respond to this request within thirty (30) days of the date hereof. Failure to do so may result in the filing of litigation against you without prior notice."

The insurer's attorney promptly responded, by letter of April 14, 1986, that:

> "[F]actors constituting preconditions to our duty to pay have not been met. We therefore perceive no duty to proceed further at this time. More specifically, we will not be reimbursing the [private health carrier] as you requested."

In December, 1986, the private health carrier filed a law suit in federal court naming claimant as the sole defendant. The suit sought the following relief: (1) reimbursement for the payment of medical and temporary disability benefits in the amount of $5,544.95; (2) attorney fees; and (3) costs.

In order to minimize his liability, claimant filed a Confession of Judgment in federal court agreeing to pay his private health carrier $5,500. Before the judgment was entered, claimant's attorney sent a copy of the judgment to the insurer's attorney requesting his comments. By letter of May 6, 1987, the insurer's attorney responded, inter alia:

> "It is our position the Disputed Claim Stipulation imposes on the parties a mutual duty to cooperate in resisting any efforts at recovery claimant's private health carrier might make. By stipulating to judgment against himself and in favor of the [private health carrier], your client

> has not only failed to cooperate with us in resisting their efforts, but has in fact joined forces with them. Consequently, we will resist any efforts [claimant] may make to enforce the Stipulation on the basis of his Stipulated Judgment."

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On June 3, 1987, claimant filed a request for hearing to, inter alia, enforce the terms of the DCS.

ULTIMATE FINDINGS

The DCS required mutual cooperation between claimant and the insurer in any arbitration or court proceeding undertaken by claimant's private health carrier to secure reimbursement of previously paid benefits.

Claimant, through his attorney, initially attempted to fully cooperate with the insurer. After unsuccessful attempts to obtain reimbursement from the insurer pursuant to the DCS, claimant entered into a Confession of Judgment with his private health carrier.

The insurer violated the terms of the DCS by not cooperating with claimant before, during, and after the court proceeding commenced by his private health carrier.

CONCLUSIONS OF LAW

Jurisdiction

The Referee declined to reach the merits of this case, reasoning that the Hearings Division lacked jurisdiction to enforce the DCS. Specifically, the Referee found that inasmuch as claimant had "traded in" her claim for a DCS, there was no "matter[] concerning a claim" under ORS 656.708(3), in which to vest jurisdiction in the Hearings Division.

After the Referee's order, the Court of Appeals held that a DCS constitutes a "claim" sufficient to vest jurisdiction in the Hearings Division. Howard v. Liberty Northwest Ins., 94 Or App 283 (1988). Concluding that the Hearings Division had jurisdiction to enforce a DCS, the Howard court stated:

> "Although the solution is not free from doubt, we conclude that, because the [DCS] resolved a dispute involving a worker's right to receive compensation, which was resolved, as it must have been, within the workers' compensation system by an agreement which the Board had jurisdiction to approve or disapprove, the Board has jurisdiction to supervise its enforcement. Accordingly, claimant is entitled to a hearing on any question concerning it. ORS 656.283." (Emphasis added).

94 Or App at 286-87; see also EBI Companies v. Moore, 90 Or App 99, 102 (1988).

Finding no meaningful distinction between Howard and the instant case, we conclude that the Hearings Division had jurisdiction to enforce the DCS.

The Merits: Enforcement of the DCS

The insurer declined to indemnify claimant on the grounds that certain preconditions in the DCS had not been met. On April 26, 1985, the insurer indicated that it had no duty to indemnify until the issuance of a final unappealable order of an arbitrator or court. We agree. The DCS plainly stated that the insurer's duty to indemnify is "activiated [sic] only by a final, unappealable order of a court or arbitrator." Claimant had no indemnification rights until the issuance of a final unappealable order.

Understandably desiring to minimize his liability exposure and to obtain a "final unappealable order," claimant entered into a Confession of Judgment with his private health carrier. He did so, however, despite prior notice from the insurer that it viewed the judgment as a violation of the terms of the DCS. As such, the insurer made it clear that it would "resist any efforts" by claimant to enforce the DCS.

The question we must resolve is whether prior to the issuance of the Confession of Judgment, the insurer failed to cooperate fully with claimant, as required by the DCS.

In our view, the insurer intended the "cooperation clause" to allow it an opportunity to defend its liability pursuant to ORS 656.289(4). That statute provides that if a claim is resolved by way of a DCS, and the insurer and the private health carrier are unable to agree on the issue of liability or the amount of reimbursement to the private health carrier, then the matter "shall be settled" among the parties by an arbitration proceeding conducted independent of ORS Chapter 656. Accordingly, in his affadavit, the insurer's attorney stated, inter alia:

> "At the time I drafted the settlement stipulation[,] I understood that [claimant's private health carrier] would almost certainly seek reimbursement and believed they would do so under [ORS 656.289]. * * *."
>
> "This [DCS] was drafted in the belief we would have an opportunity to go before an arbitrator and present evidence why these medical expenses were not related to claimant's work activity or exposure and therefore not compensable or reimbursable under the provisions [of] ORS Chapter 656."

Hence, while we find that claimant had a duty to cooperate with the insurer insofar as not prejudicing its right to arbitrate its liability under ORS 656.289(4), we also find that the insurer had some reciprocal duty to cooperate with claimant, once it became aware that his private health carrier was demanding reimbursement from him under the threat of a "court proceeding." The "cooperation clause" did not place the duty to cooperate solely upon claimant. Rather, it required "the parties . . . to cooperate with each other fully in any arbitration or court proceeding . . . ." (Emphasis added).

Here, claimant received the demand letter from his private health carrier, in May, 1985. His attorney promptly requested the insurer to "deal directly" with the private health carrier to resolve the reimbursement dispute. The insurer, however, informed claimant that it would be taking "no action" in the matter. Given that ORS 656.289(4) required such disputes to be resolved solely between the private health carrier and the insurer, Pacific Hospital Association v. Marchbanks, 91 Or App 459, 462-63 (1988), we find that the insurer's refusal to take any action whatsoever was a violation of the DCS's requirement of mutual cooperation.

The insurer resisted all efforts by claimant to obtain reimbursement pursuant to the DCS, while contemporaneously insisting that claimant obtain a "final unappealable order." Although claimant requested the insurer to deal directly with his private health carrier, the insurer never attempted to invoke arbitration proceedings under ORS 656.289(4). After claimant finally did obtain a "final unappealable order," by way of the Confession of Judgment, the insurer claimed that claimant had prejudiced its right to arbitrate the matter.

Given such circumstances, we find that the insurer violated the "cooperation clause" of the DCS well before the entry of the Confession of Judgment in May, 1987.

Penalty and Attorney Fee

The reimbursement to which claimant is entitled is not "compensation." Howard, supra, 94 Or App at 287. Accordingly, he is entitled to neither a penalty nor an attorney fee. See ORS 656.262(10).

ORDER

The Referee's order, dated March 22, 1988, is reversed. Liberty Northwest Insurance Corporation is directed to indemnify claimant in the amount of $3,000 pursuant to the Disputed Claims Settlement.

LLOYD O. FISHER, Claimant — WCB 86-12382
Emmons, Kyle, et al., Claimant's Attorneys — October 10, 1989
Acker, Underwood, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Huff's order that: (1) declined to find that his claim was prematurely closed by a Determination Order; and (2) upheld the insurer's denial of his claim for aggravation.

The Board reverses the order of the Referee.

ISSUES

1. Whether claimant's compensable left wrist claim was prematurely closed by a Determination Order.

2. Whether claimant established an aggravation of his compensable left wrist condition.

FINDINGS OF FACT

Claimant compensably injured his left wrist in 1982. His condition was diagnosed as a non-union scaphoid fracture. In March, 1986, Dr. Fleshman, an orthopedic surgeon, inserted a Herbert screw in claimant's left wrist. X-rays taken a few months later showed that the Herbert screw had failed to bridge the non-union fracture. At that time, Fleshman did not recommend further surgical intervention.

A Determination Order initially closed claimant's claim in September, 1986. Shortly thereafter, claimant returned to work as a seasonal cannery worker. Due to increasing left wrist pain, further x-rays of his left wrist were taken in November, 1986. The x-rays revealed a deterioration of the non-union fracture. Claimant's increasing pain was, in part, due to irritation from the Herbert screw.

In January, 1987, claimant's claim was reopened and Dr. Fleshman surgically removed the Herbert screw from claimant's left wrist. Two months later, Fleshman referred claimant to a physical therapist for rehabilitation of his left wrist. After a few weeks of therapy, claimant's pain decreased and his grip strength improved.

On March 27, 1987, Dr. Fleshman released claimant to light duty work. Fleshman anticipated, at that time, that claimant's left wrist condition would become medically stationary on April 30, 1987. Shortly after March 27, 1987, Fleshman discontinued his medical practice to begin church mission work in Nepal. In June, 1987, claimant began to treat with Dr. Korn, a plastic surgeon.

A Determination Order issued on July 1, 1987, awarding no permanent disability and temporary disability from December 1, 1986, through April 20, 1987.

In August, 1987, claimant was reexamined by Dr. Korn.

ULTIMATE FINDING OF FACT

Claimant's left wrist condition was not medically stationary on April 20, 1987.

CONCLUSIONS OF LAW

Premature Claim Closure

To set aside a Determination Order as premature, a worker must prove that his compensable condition was not medically stationary at the time of claim closure. Brad T. Gribble, 37 Van Natta 92 (1985). Medically stationary means that "no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). The trier of fact may consider evidence that was not available to the Evaluation Section, if such evidence addresses the worker's condition at the time of claim closure. Scheuning v. J. R. Simplot & Co., 84 Or App 622 (1987).

Here, Dr. Fleshman performed surgery on claimant's left

wrist in January, 1987. Two months later, claimant's wrist condition began to improve as the result of physical therapy treatments. On March 26, 1987, claimant's vocational counselor, Mr. Kennedy, sent Fleshman a letter requesting his opinion on claimant's ability to return to work. Fleshman responded on March 27, 1987, by stating: (1) that claimant was released for light duty work effective March 30, 1987; and (2) that claimant's projected medically stationary date was April 30, 1987.

In a chart note, dated March 27, 1987, Dr. Fleshman further reported:

> "[C]laimant [c]ontinues with PT. Is very pleased and is getting better ROM and less pain and marked improvement in strength. He is in Voc Rehab program now, and hopefully, will soon find some sort of work. He is so pleased with the PT that we will have him continue for 3 weeks and hopefully thus get him pointed in an effective way towards rehabilitation and back in the work force." (Emphasis added).

On July 1, 1987, a Determination Order closed claimant's claim effective April 20, 1987.

Dr. Fleshman never declared claimant's left wrist condition medically stationary. Fleshman's statements are merely anticipatory. See Volk v. SAIF, 73 Or App 643, 646 (1985). The evidence establishes that prior to April 20, 1987, claimant's left wrist condition was materially improving as a result of physical therapy treatment. On March 27, 1987, Fleshman noted claimant's improvement and recommended three weeks of "continue[d]" physical therapy treatment. In our view, affirmatively recommending three weeks of continued treatment is not the equivalent of declaring a worker medically stationary. See ORS 656.005(17).

On this record, we conclude that claimant's left wrist condition was not medically stationary on April 20, 1987. Accordingly, the Determination Order of July 1, 1987, prematurely closed claimant's compensable left wrist claim.

Aggravation

Because we have found above that claimant's claim was prematurely closed, we need not address the issue of aggravation. Linda S. Beaman, 40 Van Natta 8, 10 (1988).

ORDER

The Referee's order dated February 29, 1988, is reversed. The Determination Order of July 1, 1987, is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded an approved fee of 25 percent of claimant's increased compensation resulting from this order through the time of claim closure pursuant to ORS 656.268, not to exceed $3,800. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $829.50.

BRUCE W. HENION, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 88-00580
October 10, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Wilson's order that: (1) declined to find that the insurer had issued a denial of medical services; and (2) declined to assess a penalty or attorney fee. In addition, claimant requests that the Board remand this case to the Referee for further evidence taking.

The Board affirms the order of the Referee and denies the request for remand.

ISSUES

1. Whether the insurer issued a denial of medical services.

2. Whether a penalty or attorney fee should be assessed.

3. Whether remand is appropriate.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Medical Services

In a prior order, which was not appealed, the Referee ordered claimant to select an attending physician. Claimant did not do so.

In that same prior unappealed order, the Referee ordered the insurer to provide attendant care through a provider such as Quality Care "or some other qualified concern . . . ." The insurer did so, but claimant eventually refused the provider's services.

The insurer did not issue a denial, "de facto" or otherwise, of medical services.

CONCLUSIONS OF LAW

The Board adopts the Referee's opinion with the following supplementation.

Remand

The Board may remand a case should it determine that the record has been improperly, incompletely or otherwise insufficiently developed or heard by a Referee. ORS 656.295(5). To merit remand for additional evidence taking, it must be shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Claimant asserts that he became ill and unable to testify prior to the hearing. He was apparently advised, however, by his previous attorney, that his testimony would not be

necessary. He now seeks remand for the purpose of entering his testimony into the record.

Although claimant was not present at the hearing, he was represented by legal counsel. There was no indication on the record that he was ill or unable to testify. No motions were made on his behalf, either prior to or at the hearing, to postpone or leave the record open for his testimony. In fact, his attorney agreed that his testimony was not necessary or required.

Under such circumstances, we find that claimant's testimony was available at the time of the hearing with due diligence. Kienow's Food Stores, supra. Remand is, therefore, not warranted.

ORDER

The Referee's order, dated March 18, 1988, is affirmed. A client-paid fee, not to exceed $750, is approved.

KEITH L. JEGGLIE, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Cummins, et al., Defense Attorneys

WCB 87-10847 & 86-17048
October 10, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Freres Lumber Company requests review of Referee Baker's order which: (1) found that claimant had established good cause for untimely requesting a hearing on its denial of claimant's "new injury" claim for bilateral carpal tunnel syndrome; (2) set aside its denial; and (3) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition. In its brief, Freres contends that the Referee erred in allowing Dr. Rosenbaum to read a previously written narrative into the record. Claimant cross-requests review, contending that, if Freres' denial is upheld, Liberty Northwest's denial of aggravation should be set aside. On review, the issues are jurisdiction, responsibility and admission of evidence.

We affirm and adopt the Referee's order with the following comment. Recently, the Court of Appeals in Cowart v. SAIF, 94 Or App 288 (1988), held that a claimant who failed to file a timely hearing request on the basis that he thought the insurer had sent the denial letter to his attorney, when in fact it had not, consitituted excusable neglect. Id at 291. Concluding that excusable neglect is good cause under ORS 656.319(1)(b), the court held that claimant had established good cause for the untimely filing. Id.

Similarly, in the instant case, claimant's untimely filing was based on his inaccurate belief that Freres had sent a copy of its denial to his attorney. As in Cowart, supra, this constitutes excusable neglect which is good cause for an untimely request for hearing. ORS 656.319(1)(b).

Turning to the merits, we find that claimant's work activities for Freres independently contributed to a worsening of his bilateral carpal tunnel syndrome. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). In reaching this finding, we rely upon the nerve conduction studies which

demonstrated a worsening of claimant's condition since claimant worked for Freres. We further rely upon Dr. Hubbard's recommendation for surgery, claimant's testimony, and the opinion of Dr. Rosenbaum. Consequently, we agree with the Referee that Freres is responsible.

ORDER

The Referee's order dated December 1, 1987 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $600, payable by Freres Lumber Company. A client-paid fee, not to exceed $907, payable by Liberty Northwest Insurance Corporation to its counsel, is approved. A client-paid fee, not to exceed $1,284, payable by Freres Lumber Company's claims administrator to its counsel, is approved.

BRETT A. JOHNSON, Claimant	WCB 86-11007
Peter O. Hansen, Claimant's Attorney	October 10, 1989
Mark Bronstein (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Bennett's order that: (1) affirmed a Determination Order that found claimant medically stationary on June 23, 1986; (2) awarded 10 percent (32 degrees) unscheduled permanent disability for his low back condition, whereas the Determination Order awarded no permanent disability; and (3) authorized offset of overpaid temporary total disability against claimant's award of permanent disability. The issues on review are premature claim closure, extent of permanent disability, and temporary total disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Summary of Evidence."

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion" on the issues of premature claim closure and extent of permanent disability. We reverse the Referee's authorization of offset for overpaid temporary total disability.

On June 17, 1985, claimant was released for regular work by his treating chiropractor, Dr. Walsh. This was a trial release which was unsuccessful. Claimant worked for less than an hour on June 28, 1985 because his restrictions prevented him from performing his assigned work. He began treating with Dr. Cannard, chiropractor, who informed SAIF that claimant was not medically stationary on July 11, 1985. SAIF received another report from Dr. Cannard on August 19, 1985 that claimant was not yet medically stationary.

SAIF continued to pay temporary total disability until November 25, 1985, when claimant went to work for another employer.

The Referee found that claimant had not shown that he was unable to return to work, having been released for a trial return to work by Dr. Walsh as of June 23, 1985. He therefore authorized SAIF to offset temporary total disability for the period June 28, 1985 to November 25, 1985. We disagree.

Despite the fact that claimant had been released for a trial return to work by Dr. Walsh, the evidence establishes that claimant was unable to return to work until November 25, 1985, when he returned to work for a different employer.

Once an insurer accepts a claim and commences payment of temporary disability benefits, it must continue paying those benefits until claim closure except in the following limited situations. First, an insurer may terminate benefits prior to claim determination when a claimant returns to regular work or is released to regular work and is medically stationary. See Fazzolari v. United Beer Distributors, 91 Or App 592 (1988), recon 93 Or App 103, rev den 307 Or 236 (1988). Second, an insurer may suspend benefits when a claimant "accepts and commences" wage-earning employment paying a wage equal to or greater than the wage at injury. See OAR 436-60-030(3). We find that happened here on November 24, 1985. Third, an insurer may suspend benefits when a claimant refuses suitable employment.

We find that claimant was both procedurally and substantively entitled to temporary total disability payments from June 28, 1985 to November 24, 1985. During that period of time he was not medically stationary and had not returned either to regular work or to another job. SAIF was not entitled to discontinue temporary disability periods during that time. Fazzolari v. United Beer Distributors, supra. Furthermore, because claimant was both procedurally and substantively entitled to receive the payments, no offset against present or future permanent disability awards is authorized. See Blythe A. Chesselet, 40 Van Natta 1930 (1988). Consequently, claimant is entitled to the entire 10 percent unscheduled permanent disability award granted by the Referee's order, with no reductions for an offset.

ORDER

The Referee's order dated December 2, 1987, is reversed in part. Claimant is entitled to temporary total disability between June 28, 1985 and November 25, 1985. Therefore, that portion of the Referee's order that authorizes SAIF to offset the aforementioned temporary total disability payments against claimant's award of permanent disability is reversed. SAIF's request for offset is denied. Claimant is entitled to the entire 10 percent (32 degrees) unscheduled permanent disability award granted by the Referee without deduction of the offset. Claimant's attorney is entitled to 25 percent of the increased compensation created by this order, not to exceed $3,000. The remainder of the Referee's order is affirmed.

LAREE A. KELLAR, Claimant	WCB 87-04721
Carney, et al., Claimant's Attorneys	October 10, 1989
Cliff, Snarskis, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee Bethlahmy's order that: (1) set aside its partial denial of medical services for claimant's bronchial condition; and (2) assessed attorney fees for an unreasonable denial. On review, the issues are medical services and attorney fees.

The Referee's order is affirmed, with modification.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following supplementation.

Claimant's employment exposure to a brine solution containing a high concentration of sulphur dioxide caused a condition of bronchial hyperactivity which has developed into a sensitivity to exposure to certain irritant fumes.

Claimant's bronchial hyperactivity is aggravated by her smoking one or more packs of cigarettes per day. However, her compensable injury is a material contributing cause of her current need for medical treatment and disability for her bronchial condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the employer's denial of medical services was an impermissible "back up" denial. See Bauman v. SAIF, 295 Or 788 (1983). We disagree with that reasoning, but do agree that the denial of medical services was not valid. When a claimant is denied treatment by way of a prospective denial of all future treatment, that denial must be set aside. See Robert M. Bryant, 41 Van Natta 324 (1989); Thomas A. Beasley, 37 Van Natta 1514 (1985).

Here, claimant submitted claims for medical services three years after her compensable injury and after changing work environments. The insurer denied "responsibility for any further medical treatment and/or disability from the above-captioned industrial exposure." (Ex. 34). Inasmuch as the employer's denial is prospective, it shall be set aside.

Alternatively, on the merits, we find that claimant's current bronchial condition is causally related to her previously accepted claim and thus, medical services are compensable.

We disagree, however, with the reasoning of the Referee that claimant's medical services are currently compensable simply because claimant was previously awarded permanent disability. A finding of permanent disability does not preclude denial of subsequent medical services on the grounds that claimant's condition is not related to the compensable injury. See North Clackamas School Dist. v. White, 305 Or 48 (1988), modified 305 Or 468 (1988).

An injured worker is entitled to all reasonable and necessary medical services for a compensable injury. ORS 656.245. In order to prove compensability of medical services, the compensable injury need not be the sole cause, or the most significant cause of the need for treatment, but only a material cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Here, the medical record demonstrates that claimant's compensable injury was a material cause of her need for current medical services. Notwithstanding claimant's continued use of cigarettes, Dr. Greve, a pulmonary specialist, persuasively concluded that claimant's employment exposure to brine fumes caused her lungs to develop a sensitivity to other fumes.

Thus, notwithstanding the cigarette smoke, claimant has proven by a preponderance of the evidence that the industrial exposure was a material cause of her present condition. Accordingly, we find that claimant's current medical services are related to her 1984 compensable injury.

With respect to the issue of unreasonable denial, we adopt that portion of the Referee's "Conclusions and Reasons" which addresses the matter.

ORDER

The Referee's order of October 26, 1987 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded a reasonable fee of $750, to be paid by the insurer.

PATRICIA A. KINGSLAND, Claimant	WCB 83-09748
Bottini, et al., Claimant's Attorneys	October 10, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Bethlahmy's order that: (1) found that her neck and left shoulder claim was not prematurely closed; and (2) upheld the insurer's aggravation denial for the same condition. We affirm.

ISSUES

1. Premature closure; or, alternatively,

2. Aggravation.

FINDINGS OF FACT

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

Claimant underwent a supervised exercise program commencing in May, 1983. Dr. Hummel noted in June, 1983 that claimant was regularly doing her exercises. These exercises yielded only transitory benefits.

FINDINGS OF ULTIMATE FACT

Claimant's condition did not change from July 21, 1983 to August 21, 1984.

Claimant's condition on July 21, 1983 was such that no further material improvement would reasonably be expected from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Claims shall not be closed if the worker's compensable condition has not become medically stationary. ORS 656.268(1). An injured worker will be considered medically stationary when no

further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J. R. Simplot & Co., 84 Or App 622, 625, rev den 303 Or 590 (1987).

Claimant alleges two bases upon which we should find that her claim was prematurely closed by the September 22, 1983 Determination Order. First, claimant relies on Dr. Long's October 5, 1983 report indicating that claimant was not medically stationary because she "has not been involved in a regular supervised exercise program." Second, claimant argues that her claim was prematurely closed because she subsequently underwent surgery for thoracic outlet syndrome which was performed with "a reasonable hope of further medical improvement." See Scheuning, 84 Or App at 626.

The insurer contends that, despite Dr. Long's statement to the contrary, claimant had in fact undergone a supervised exercise program prior to claim closure. The insurer further contends that this prior program yielded no improvement in claimant's condition; and, therefore, that this prior lack of success renders unreasonable any expectation of improvement Dr. Long may have had. With regard to claimant's subsequent surgery, the insurer argues that such surgery did not result in any improvement in claimant's condition. The insurer also argues that subsequent developments show claimant probably never had thoracic outlet syndrome and that the surgery was ill-advised. The insurer, therefore, concludes that improvement in claimant's condition could not reasonably have been expected when the claim was closed.

The record establishes that claimant did participate in a supervised exercise program prior to claim closure. Dr. Hummel reported in this regard that claimant was following the prescribed program "with regularity and some vigor." However, the program resulted in no curative benefits. Consequently, we agree, that absent some change in circumstances, Dr. Long's subsequent recommendation of a supervised exercise program fails to establish a reasonable expectation of further material improvement in claimant's condition.

Whether the subsequent thoracic outlet syndrome diagnosis and surgery establishes premature closure is a closer question. However, our review of the medical record, including that portion dealing with the thoracic outlet syndrome diagnosis and surgery, does not persuade us that further material improvement in claimant's condition could reasonably be expected as of the date of closure. We note in this regard that it is claimant's burden to establish that she was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Co., 54 Or App. 624 (1981).

Here, despite the fact that claimant had surgery which was compensated by the insurer, claimant has failed to persuade us that she suffered from thoracic outlet syndrome. This conclusion is based upon several facts. Claimant's condition did not improve following surgery. Dr. Hummel had initially considered thoracic outlet syndrome as a possible cause of claimant's symptoms, but he subsequently rejected the possibility. Prior to referral to

Dr. King, Dr. Long opined that "there [was] little clear cut evidence to support the possibility of left thoracic outlet syndrome." Finally, post-surgery, Dr. Long referred to the diagnosis as "presumptive," whereas previously he used no such qualifier.

In light of the fact that we find the thoracic outlet syndrome to be a misdiagnosis, we cannot conclude that the post-closure diagnosis and subsequent surgery support a reasonable expectation of further material improvement in claimant's condition as of the date of closure. Consequently, claimant's claim was not prematurely closed.

Aggravation

The Board adopts the Referee's opinion on this issue.

ORDER

The Referee's order dated October 1, 1987, as reconsidered, is affirmed. The Board approves a client-paid fee, not to exceed $1,078.

THOMAS L. LINGO, Claimant
Malagon & Moore, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-04232
October 10, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Howe's order that: (1) upheld the insurer's partial denial of claimant's medical services claim for current dental care; (2) upheld the insurer's denial of claimant's aggravation claim for his left shoulder condition; (3) upheld the insurer's partial denial of claimant's medical services claim for chiropractic care; and (4) upheld the insurer's partial denial of claimant's psychological treatments. We affirm as supplemented.

ISSUES

The first issue is the compensability of claimant's current dental care. The second issue is the compensability of a claim for aggravation. The third issue is the compensability of current chiropractic care. The final issue is the compensability of claimant's psychological condition.

Claimant also seeks remand to the Hearings Division due to the alleged inadequacy of the Referee's opinion and order. On de novo review, we are free to make any disposition of the case as is deemed appropriate. Destael v. Nicolai, 80 Or App 596, 600 (1986). Such action would necessarily include issuing an order, which contained findings of fact, conclusions of law, and an explanation of the reasoning behind our conclusions. Thus, our order may cure any problems with whether the Referee's order is sufficient for substantial evidence review at the Court of Appeals. Consequently, we conclude that the record has not been improperly, incompletely, or otherwise insufficiently developed. See ORS 656.295(5). Therefore, the remand request is denied.

FINDINGS OF FACT

On March 11, 1986, while working for a neon sign company, claimant fell from his truck as he was attempting to erect a sign. Immediately after the accident, claimant sought medical treatment for his left shoulder from an emergency room physician. Claimant was diagnosed with a dislocated left shoulder, which was reduced at that time.

Claimant sought dental services from Dr. Boer, dentist, on April 3, 1986, for a loose lower anterior tooth. Dr. Boer's partial dental examination also revealed severe to moderate bone loss and extensive periodontal disease affecting all of the lower teeth. With respect to the one tooth, Dr. Boer noted greater bone loss than other adjacent teeth, but specific etiology could not be directly linked to trauma.

Previous to this, claimant had sought dental care from Dr. Hoerner from 1981 to 1983 for a periodontal disease condition, which had also manifested itself in missing teeth, loose teeth, and bone loss. At that time, claimant had chosen not to commence with recommended treatment in the form of extraction and denture replacement.

Follow-up treatment for the left shoulder was provided by Dr. Poulson on March 12, 1986. Dr. Poulson, in turn, referred claimant to Dr. Buttler, a chiropractor, for physical therapy.

Prior to his 1986 injury, claimant had injured his mid and lower back in 1962. This injury eventually resulted in a laminectomy and diskectomy. In 1970, claimant suffered a second spinal injury, which resulted in a fusion extending from L4 through the sacrum. In addition, claimant has had intermittent aggravations throughout the years, including a reinjury in 1981.

An arthrogram of the left shoulder was done on May 21, 1986, by Dr. Pappas, which revealed a torn left rotator cuff. On June 12, 1986, in a pre-surgical work-up, Dr. Poulson also discovered that claimant's gums were infected. He recommended abatement of this condition prior to left rotator cuff surgery.

On June 16, 1986, the insurer indicated it would pay all dental services that arose out of claimant's compensable injury. On July 7, 1986, the insurer further indicated it would pay for dental services that constituted "necessary work on Mr. Lingo so he can have surgery on his shoulder."

On July 16, 1986, Dr. Boer indicated that control of the periodontal disease would require extensive teeth extraction, and referred claimant to a dental surgeon. On July 24, 1986, claimant was seen by dental surgeon, Dr. Brasher, who diagnosed "chronic periodontitis, generalized and advanced." To control the oral infection he recommended removal of teeth, periodontal scaling/root planing, and periodontal flap surgery.

On September 3, 1986, claimant was seen by Dr. Shoemaker, another dental surgeon, who recommended teeth extraction with replacement of bridge or implant dentures. The actual dental surgery was accomplished by Dr. Nasibutt, who extracted the teeth and replaced them with a bridge for the lower jaw, and implant dentures for the upper jaw.

On September 22, 1986, Dr. Poulson indicated that claimant's dental problems were sufficiently resolved so that left shoulder surgery could commence. Rotator cuff surgery was conducted by Dr. Poulson on October 10, 1986. Following surgery, Dr. Poulson again referred claimant to Dr. Buttler, for post-operative physical therapy for the left shoulder.

In December of 1986, Dr. Naisbutt replaced the lower bridge with an implant denture.

In February of 1987, claimant was referred to the Northwest Pain Center. While there, he was examined by Dr. Labs, a clinical psychologist, who diagnosed chronic depression.

On May 22, 1987, the insurer issued a partial denial, denying all conditions and medical services not related to the compensable left shoulder injury.

A Determination Order issued on June 18, 1987, awarding claimant 25 percent (80 degrees) unscheduled permanent partial disability for his left shoulder.

On July 22, 1987, Dr. Buttler authorized time loss for "acute aggravation of cervical, thoracic and left shoulder sprain and myalgia." The insurer denied claimant's aggravation claim by letter on August 3, 1987.

Dr. Buttler referred claimant to Dr. Flemming, a psychologist. Dr. Flemming diagnosed "anxiety" and began treating claimant with psychotherapy and biofeed-back techniques to relieve back tension.

On September 15, 1987, the insurer, upon receiving Dr. Flemming's report, issued a partial denial, denying claimant's medical services claim for psychological treatments on the basis the treatment was not related to the compensable claim.

On September 18, 1987, the insurer issued a partial denial for claimant's chiropractic care. This denial stated as follows: "We will pay billings for services provided by Dr. Buttler up to 60 days before the date of this denial letter, but we will pay for no further treatment provided by Dr. Buttler." The basis of the denial was that chiropractic care was neither reasonable nor necessary, as it was not related to the left shoulder condition.

Claimant was examined by Independent Chiropractic Consultants on November 9, 1987. They found claimant medically stationary with respect to the left shoulder condition. They also noted degenerative changes in the lumbar spine and in the cervical spine at the C5-6 level.

On November 7, 1987, Dr. Holland, psychiatrist, conducted a psychological examination of claimant. He made no diagnosis of a psychological condition requiring treatment.

ULTIMATE FINDINGS OF FACT

Claimant's compensable injury is not a material cause of his need for current dental care.

Claimant's dental work consisting of those measures to control and correct claimant's preexisting periodontal disease, was a necessary prerequisite to total treatment of claimant's compensable left shoulder surgery.

Claimant's restorative dental work, to provide him with upper and lower dentures, was not a necessary prelude to the compensable surgery to repair the left shoulder rotator cuff.

Claimant's compensable left shoulder condition has not worsened since the last award or arrangement of compensation.

The preponderance of the evidence does not establish that claimant's chiropractic care was causally related to the compensable left shoulder condition.

The preponderance of the evidence does not establish that claimant's compensable left shoulder injury was a material contributing cause of any psychological condition.

CONCLUSIONS OF LAW

Medical services claim for dental care

The Referee upheld the insurer's partial denial of May 22, 1987, which denied all medical services unrelated to the compensable injury. The Referee found that the compensable left shoulder injury was not a material contributing cause of any of the dental care. The Referee noted that the insurer authorized payment for teeth extraction to control the pervasive gum infection, including payment of claimant's upper implant denture and lower bridge. He then held that the dental work which encompassed replacement of the lower bridge with an implant denture was not a reasonable and necessary medical expenditure.

We agree with that aspect of the Referee's decision which holds that claimant has not carried his burden of proof with respect to the establishment of a causal connection between the compensable injury and that dental care. We also concur with the Referee that the insurer is not required to pay for claimant's lower implant denture.

We further endorse the Referee's implicit premise that dental care required to control the gum infection was a necessary prerequisite to the shoulder surgery, and was therefore, to be considered compensable medical services. We note that the insurer accepted liability for this care and concedes that it is compensable. However, we disagree with that portion of the Referee's opinion, which holds by implication that the upper implant denture and lower bridge denture were to be included in those compensable consequences of the left shoulder surgery. We specifically disavow the Referee's opinion insofar as it can be read to find denture-related medical services compensable. Yet, since the Referee upheld the insurer's May 22, 1987, denial in its entirety, no further action is necessary.

To prove compensability, claimant must show that the compensable injury was a material contributing cause of the need for reasonable and necessary medical services. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987). As a corollary to this proposition, medical services are compensable if they constitute required preliminary procedure, and

hence, it can be said that they form an integral part of total medical treatment for the compensable injury. Williams v. Gates, McDonald & Co., 300 Or 278 (1985).

The medical record indicates that prior to the injury, claimant suffered from missing teeth, loose teeth, and bone loss throughout his mouth. This long-standing condition was first identified in 1981 by Dr. Hoerner, and diagnosed as periodontal disease. At that time, claimant chose not to follow his dentist's treatment recommendation of extraction with denture replacement.

Similarly, claimant's recent gum infection also manifested itself in missing teeth, loose teeth, and bone loss. On July 16, 1986, claimant's treating dentist, Dr. Boer, indicated that the major contributing cause of claimant's dental condition was: (1) periodontal disease (gum infection); (2) missing teeth; and (3) tooth decay. Dr. Brasher, dental surgeon, diagnosed generalized periodontal disease in the advanced stages. Dr. Naisbutt, treating dental surgeon, noted preexisting periodontal disease as well.

Claimant's dentists, however, also have noted claimant's historical statements regarding a facial injury occurring on March 11, 1986. Claimant's treating dental surgeon, Dr. Naisbutt, indicated that such trauma, as described by claimant, would cause a more severe injury to the already preexisting periodontal disease.

Therefore, any material contribution by the compensable March 11, 1986, injury to the current dental condition, ultimately depends upon claimant's credibility in providing an accurate history of trauma to his mouth. The Referee specifically found claimant not credible. The Referee noted various inconsistencies throughout the medical record as to the events of March 11, 1986. However, the Referee's finding that claimant was not credible was based primarily on claimant's demeanor as a witness at hearing. Based on demeanor, the Referee found claimant's version of events to be false, and the testimony of the other witnesses to be truthful. 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, 393 (1987). Finding no persuasive reason to refrain from following our general approach, we will not disturb the Referee's demeanor-based credibility finding.

Therefore, we hold that claimant's version of the incident in question, and history of those events provided to his physicians for incorporation into their medical reports, shall be given little weight. Turning to the objective findings, we find little, if any, medical evidence of a facial injury, broken facial bones, lacerations, knocked out teeth, or broken teeth at the time of the compensable injury.

Considering the preexisting dental condition prior to the compensable injury, the lack of objective medical evidence of trauma coupled with claimant's discredited medical history and testimony, we find claimant has not established that the dental care was a material contributing cause of the March 11, 1986 injury.

However, we do find that under the Williams analysis, claimant has demonstrated that the need for dental care, insofar

as it concerned the eradication of the gum infection, was a necessary prerequisite to total treatment for the left shoulder condition. On June 12, 1986, Dr. Poulson in a pre-surgical examination of claimant discovered the gum infection and the need to eliminate it prior to proceeding with surgery.

Both Dr. Boer, treating dentist, and Dr. Brasher, consulting dental surgeon, indicated that primary control and elimination of the extensive gum infection would require numerous tooth extractions. Therefore, this element of claimant's dental care is compensable. Williams, supra; See also, Senner v. SAIF, 91 Or App 704 (1988).

Yet, claimant's dental care proceeded to include substantial work on his dentures, in the form of an upper implant and lower bridge, followed by replacement of the lower bridge with an implant denture. The dental reports indicate the denture work as being restorative in nature, and not related to control of the oral infection which was the prerequisite to the shoulder surgery. Accordingly, dental care in excess of the need to control the oral infection is not compensable.

Aggravation

The Referee upheld the insurer's denial of claimant's aggravation claim of July 22, 1987, finding there was no worsening of the left shoulder condition from the last award of compensation, which was a Determination Order issued on June 18, 1987, awarding 25 percent unscheduled permanent disability for the left shoulder. We agree.

To establish an aggravation, claimant has the burden of proving that his condition has worsened since the date of the last arrangement of compensation, and that the worsening was caused in material part by the compensable injury. ORS 656.273(1); Stepp v. SAIF, 78 Or App 438 (1986). To prove a worsening, claimant must show a change in his condition which renders him less able to work, and thus entitles him to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396, 399-402 (1986); See also Gwynn v. SAIF, 304 Or 345 (1987).

The totality of the medical record indicates that claimant's left shoulder condition has not worsened since the last award of compensation. On July 22, 1987, claimant's treating chiropractor, Dr. Buttler, authorized time loss for an "acute aggravation of cervical, thoracic, and left shoulder sprain and myalgia." However, this "fill-in-the-blanks" form letter was conclusory and is not persuasive.

In a more in-depth medical report, dated August 19, 1987, Dr. Buttler indicated he was treating claimant for the following condition:

> "Acute traumatic cervical sprain and myalgia with concurrent thoracic sprain and myalgia and lumbosacral sprain and myalgia complicated by intervertebral disc degeneration and surgical fusion further complicated by left shoulder sprain and strain secondary to post-traumatic separation and subsequent surgical repair of torn rotator cuff."

Later in the same report, Dr. Buttler opines that claimant's condition has worsened necessitating an increase in treatment. However, Dr. Buttler does not specify that the "condition" to which he primarily refers to is claimant's left shoulder. Accordingly, we do not find Dr. Buttler's report of July 22, 1987, to be persuasive.

We particularly do not find it persuasive when viewed in light of the other medical evidence. Dr. Poulson, claimant's treating physician for the left shoulder, indicated claimant's shoulder has been doing well since March of 1987. The closing examination took place on May 5, 1987, which indicated mild impairment based primarily on limited range of motion. These range of motion figures show little variance with those reported by Dr. Buttler in his August 19, 1987, report. Moreover, since May 5, 1987, claimant has not sought any further treatment from Dr. Poulson for his left shoulder.

In addition, the Independent Chiropractic Consultants do not support a worsening of claimant's compensable injury. Instead, they indicated that with respect to the left shoulder, claimant had no complaints, and was medically stationary with mild permanent impairment post-surgery. Noting objective findings of degenerative disease in the cervical and lumbar back, the Consultants also indicated that claimant's chief complaints were headaches "that were localized to the posterior cervical region and radiate in a band like fashion," as well as neck pain and tenderness with decreased range of motion in the neck.

Accordingly, the medical record is sparse with respect to the nature of the left shoulder aggravation, and its cause. In fact, the evidence indicates that the aggravation described by Dr. Buttler refers to claimant's preexisting cervical back condition. As such, there is little in the way of persuasive evidence that claimant's shoulder condition has worsened. Consequently, claimant has failed to carry his burden of proof by a preponderance of the evidence with respect to a reopening of the March 11, 1986 left shoulder injury claim.

Medical services claim for chiropractic treatments

The Referee also concluded there was no causal connection between the chiropractic treatments and the compensable injury. We agree.

Claimant has the burden of establishing by a preponderance of the evidence that the compensable injury was a material contributing cause of the need for reasonable and necessary medical services. Van Blokland v. Oregon Health Sciences University, supra. Claimant has not met the requisite burden of proof concerning his chiropractic treatments.

Claimant was initially referred to Dr. Buttler by Dr. Poulson for post-operative exercises to his left shoulder following the October 10, 1986, surgery. However, for the most part, the treatment provided by Dr. Buttler has been primarily focused on claimant's multiple cervical, thoracic, and lumbar back conditions. His medical reports fail to distinguish left shoulder treatment from back treatment.

Furthermore, on October 21, 1987, Dr. Poulson indicated

that the chiropractic care he initially prescribed for post-surgery recovery was no longer necessary. In addition, the Independent Chiropractic Consultants opined that claimant's current complaints were related to preexisting degenerative changes taking place in the back, and were unrelated to the compensable injury. Specifically, in regard to the left shoulder, they found it to be resolved with mild permanent residuals manifested by reduced range of motion. Consequently, they concluded that chiropractic care for the left shoulder condition was unnecessary.

We consider the opinions of Dr. Poulson, claimant's treating surgeon, and the Independent Chiropractic Consultants more persuasive than that offered by Dr. Buttler. Accordingly, claimant has failed to carry his burden of proof with respect to the compensability of the chiropractic treatments.

Psychological treatments

The Referee also upheld the partial denial denying claimant's current psychological problems as causally related to the compensable injury. We agree.

We find that claimant had a preexisting "anxiety" problem dating from 1977. The origin of this condition was rooted in past emotional traumas concerning his family relationships. We also note that claimant bases his medical services claim upon the opinion of psychologist, Dr. Flemming, that the May 22, 1987, denial was a precipitating event which caused claimant's preexisting psychological condition to become symptomatic requiring psychological treatment.

Therefore, in order to establish compensability of treatment for his psychological condition, claimant need show that the compensable left shoulder injury materially contributed to the causation of symptomatology of the psychological condition resulting in a need for treatment. Jeld-Wen v. Page, 73 Or App 136 (1985); Brian C. Roll, 40 Van Natta 2046 (1988).

We find that the medical record neither establishes a psychological condition requiring treatment, nor does it establish material contribution by the compensable injury. Dr. Flemming diagnosed claimant's psychological condition as follows: (1) "he was displaying considerable emphasis on physical complaints;" and (2) "adjustment reaction with considerable anxiety." Beyond this, Dr. Flemming does not describe or explain the nature or origins of the psychological condition, nor the need for psychotherapy. Although Dr. Flemming mentions the September 8, 1987, denial and the May 22, 1987, denial he does not describe with adequacy the effect claims processing has had on claimant's psychological condition, except to indicate that the denial letters made claimant angry and frustrated. In sum, claimant's treating psychologist does not sufficiently describe a compensable condition requiring treatment, nor does he adequately attribute causation to the compensable injury.

In contrast to Dr. Flemming, Dr. Holland, psychiatrist, stated he found no psychiatric condition which required treatment. He also stated there was no causal relationship between the claimant's psychological condition and the compensable injury. Although Dr. Holland testified at hearing that the claims processing actions made claimant unhappy and caused stress, he did

not go so far as to opine that these incidents either induced a "compensation neurosis," or make symptomatic claimant's preexisting "anxiety" condition creating a need for medical treatment.

Accordingly, we are not persuaded that claimant's compensable left shoulder injury was a material contributing cause of his need for psychological treatments. Consequently, claimant has not carried his burden of proof with respect to the compensability of his psychological condition.

ORDER

The Referee's order, dated December 1, 1987, is affirmed. A client-paid fee not to exceed $1,500, is approved.

JERRY D. MANN, Claimant
Dahn & Morrison, Claimant's Attorneys
Stafford Hazelett, Defense Attorney

WCB 87-18365
October 10, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Galloway's order that affirmed a Determination Order which awarded no permanent partial disability for his low back. The insurer cross-requests review of that portion of the order that assessed an attorney fee for failure to accept claimant's claim in a timely fashion. The insurer also moves to strike a brief filed by claimant in response to the insurer's cross-reply brief. We grant the insurer's motion to strike, grant claimant an award of permanent partial disability for his low back and reverse the attorney fee assessed by the Referee for untimely claim acceptance.

ISSUES

1. Motion to strike claimant's brief in response to the insurer's cross-reply brief.

2. Extent of disability for claimant's low back.

3. Attorney fee for untimely claim acceptance.

FINDINGS OF FACT

Claimant compensably injured his low back on June 9, 1987 when he carried a heavy piece of equipment down two flights of stairs. He left work on June 12, 1987 and subsequently sought treatment from a chiropractor, Dr. Leistikow, who diagnosed a lumbar strain or sprain. Claimant filed an 801 form with the employer on June 23, 1987. In early August 1987, Dr. Leistikow released claimant for modified work with a restriction of no repetitive lifting over 20 pounds. No modified work was available for claimant and he remained off work.

Claimant discontinued his treatment with Dr. Leistikow at the end of August 1987. The treatments were no longer effective at that time and tended to exacerbate his condition. On September 30, 1987, claimant was examined by Dr. Hardiman, an orthopedic surgeon, at the request of the insurer. The examination revealed no abnormalities except for mild pain with certain maneuvers. Dr. Hardiman opined that claimant was medically stationary and recommended claim closure. He recommended that claimant not engage in heavy work because of his

small stature. Claimant is five feet, five inches tall and weighs 130 pounds. Dr. Leistikow later rated claimant's permanent impairment as mild based upon the complaints of mild pain reflected in Dr. Hardiman's report.

The insurer deferred acceptance or denial of claimant's claim until September 10, 1987, when it accepted the claim. The insurer paid all compensation due in a timely fashion pending the acceptance. The claim was closed by Determination Order on October 30, 1987 with no award of permanent partial disability. Claimant filed a request for hearing on December 1, 1987. The application to schedule submitted with the request raised a number of issues including penalties and attorney fees. The hearing was held on February 12, 1988. At the beginning of the hearing, the parties designated vocational assistance, extent of permanent disability and offset as the issues to be litigated. The Referee decided these issues in his Opinion and Order and also ruled on the issues of penalties and attorney fees for untimely acceptance of claimant's claim.

Claimant requested Board review of the Referee's order. The insurer cross-requested review. Claimant filed a brief as appellant. The insurer then filed a brief as respondent/cross-appellant. Claimant filed a reply/cross-respondent brief. The insurer then filed a cross-reply brief. Claimant filed a further brief in rebuttal of the insurer's cross-reply brief. The insurer moved to strike claimant's last brief.

Claimant was 31 years old at the time of the hearing. He dropped out of school in the ninth grade, but later received a GED. His work history has been varied, but primarily in jobs requiring heavy or repetitive lifting. He is no longer able to perform such work due to the industrial injury.

FINDINGS OF ULTIMATE FACT

1. Claimant did not seek Board authorization for filing a brief in rebuttal of the insurer's cross-reply brief.

2. Claimant sustained minimal permanent impairment to his low back as a result of the industrial injury.

3. The issues of penalties and attorney fees were not presented to the Referee for decision.

CONCLUSIONS OF LAW

1. The Insurer's Motion to Strike

Briefs which may be submitted by the parties on Board review are specified in OAR 438-11-020(2). No other briefs filed by the parties without express authorization from the Board will be considered. Claimant's brief in rebuttal of the insurer's cross-reply brief is not one of the briefs specified in OAR 438-11-020(2). Claimant did not request Board authorization to file the brief. The insurer's motion to strike is well taken and will be granted. Claimant's brief in rebuttal of the insurer's cross-reply brief will not be considered by the Board in its review of this case.

2. Extent of Disabilty

The Referee concluded that claimant had sustained no

permanent impairment to his low back and denied claimant's request for an award of permanent partial disability. Claimant contends that the record supports the conclusion that he is permanently impaired as a result of the industrial injury. The insurer contends that claimant's entitlement to an award of permanent disability must be determined under the Director's current "Standards for the Evaluation of Permanent Disabilities" and must be proven by clear and convincing evidence pursuant to the 1987 amendments to ORS 656.295(5).

The insurer's arguments regarding the application of the Director's "Standards for the Evaluation of Permanent Disabilities" and the "clear and convincing" standard of proof are without merit. OAR 436-35-003, 438-10-005, 438-10-010; Linda L. Carroll, 40 Van Natta 1095, 1098 (1988). Claimant became medically stationary on September 30, 1987 and his claim was closed on October 30, 1987. We rate his disability under the guidelines in effect on the date of claim closure.

The criterion for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. In determining loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Claimant sustained a strain or sprain of his low back. He has mild residual pain which prevents him from performing heavy or repetitive lifting. His small stature made it difficult for him to perform such work before his injury. The residual pain resulting from the industrial injury made it impossible for him to perform such work. Claimant's inability to perform heavy and repetitive work, therefore, is a result of the industrial injury. In view of claimant's complaints of disabling pain, we rate his impairment as minimal. See former OAR 436-30-550.

Based upon claimant's minimal impairment, his relatively young age, his high school equivalency degree, his varied work history and the other relevant social and vocational factors, we conclude that claimant is entitled to an award of 10 percent (32 degrees) unscheduled permanent partial disability for his low back.

3. Attorney Fee for Untimely Acceptance of Claimant's Claim

The Referee concluded that the insurer had unreasonably failed to accept claimant's claim in a timely manner. He did not assess a penalty against the insurer because the insurer had timely paid all compensation due. He did, however, award an attorney fee under ORS 656.382(1). The insurer contends that the Referee erred in awarding this fee because the issues of penalties and attorney fees was not raised by claimant at the time of the hearing.

We agree with the insurer. The parties specified the issues to be decided by the Referee at the beginning of the hearing. Penalties and attorney fees were not among them. The parties did not develop the record on those issues. Under these circumstances, it was improper for the Referee to decide the penalty and attorney fee issues. Mavis v. SAIF, 45 Or App 1059, 1062-63 (1980); Richard C. Centeno, 41 Van Natta 619, 620 (1989).

ORDER

The Referee's order dated April 6, 1988 is reversed in part and modified in part. That portion of the order that assessed an attorney fee for untimely acceptance of claimant's claim is reversed. That portion of the order that affirmed the Determination Order which granted claimant no award of permanent partial disability is modified. Claimant is awarded 10 percent (32 degrees) unscheduled permanent partial disability for his low back. Claimant's attorney is awarded 25 percent of this compensation as a reasonable attorney fee. The remainder of the Referee's order is affirmed.

JUDY A. MERRIMAN, Claimant
Bill Dames, Claimant's Attorney
Ronald Pomeroy (SAIF), Defense Attorney

WCB 87-03914
October 10, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brown's order that: (1) affirmed a Determination Order that awarded claimant no unscheduled permanent disability for her head injury; and (2) upheld the SAIF Corporation's aggravation denial relating to the same condition. We affirm.

ISSUES

1. Extent of Permanent Disability, if any.

2. Aggravation.

FINDINGS OF FACT

Claimant was compensably injured on January 22, 1985 while working as a lumber grader. The injury resulted when she struck her right temple area against a protruding piece of lumber. The incident required no immediate medical care, and claimant completed the remaining five hours of her work shift. That evening her daughter removed imbedded wood splinters from her temple area. Claimant returned to work for a couple of days, then she was off-work thereafter due to headaches occasionally involving nausea.

On March 19, 1985, SAIF accepted a disabling contusion of the right temple.

Also in March 1985, claimant underwent an outpatient surgical procedure due to a suspicion that a foreign body remained embedded in the area of her injury. No definite foreign body was identified.

Claimant was off work due to heachaches until April 18, 1985. She returned to work for several months and then was fired. Over the next two years, claimant worked at several different jobs all for brief periods of time. Meanwhile, she commenced treatment with Dr. Conwell, neurologist, for her headaches. Dr. Conwell attempted to treat claimant's headaches with a variety of medications without success.

Claimant was arrested for driving under the influence on

January 1, 1985. Shortly thereafter, on January 15, 1985, claimant was again arrested for driving under the influence.

Claimant was living with William Heeter throughout 1985 and much of 1986. They were married in July 1986. During this period, Heeter physically assaulted claimant on multiple occasions. Sometimes Heeter would strike claimant about the head. Other times, Heeter would push claimant into objects causing bruises of the head. On one occasion, claimant was beaten so severely that she was admitted to the hospital.

A Determination Order issued on November 26, 1986 awarding claimant temporary disability benefits only.

On May 20, 1987, SAIF issued a denial of aggravation on the basis that claimant's compensable condition had not worsened.

Claimant and Heeter were involved in a car accident later in May. Heeter was driving at the time, and the accident resulted when he attempted to retrieve an object from behind him. Claimant injured her ankle in the accident. Claimant was taken to the hospital emergency room where she reported that she, rather than Heeter, had been driving the car. Claimant also stated that the accident had resulted from her attempt to avoid a deer in the road. Claimant lied because Heeter's driver's license had previously been revoked.

Claimant also reported the accident to Dr. Conwell. Claimant stated to Dr. Conwell that:

> "*** [she] drove her car into a ditch during some type of attack which she describes as beginning with a watering of the mouth, producing shortness of breath, probably some hyperventilation, intense anxiety, with numbness of the face and difficulty with hearing and seeing. These episodes began on 05/15/87, and she has had two or three of them to date, the most recent resulting in the accident and injury."

Claimant was arrested for the felony charge of hindering prosecution on July 29, 1987, when she told police officers that the person they were looking for was not in her trailer. The individual was later discovered hiding in her bedroom. Claimant had earlier been convicted in 1985 for filing a false police report.

FINDINGS OF ULTIMATE FACT

Claimant is not credible.

CONCLUSIONS OF LAW AND OPINION

Permanent Disability

In order to sustain her claim to entitlement to permanent disability, claimant relies upon her own testimony and the opinions of Dr. Conwell. The Referee, in his oral findings on the record, concluded that claimant is not credible. Consequently, the Referee found that he could neither rely on

claimant's testimony, nor the opinions of Dr. Conwell which were necessarily based upon claimant's statements to him.

There are substantial reasons in the record to conclude that claimant lacks credibility. Some of these reasons are directly related to the compensable claim. Others arise independently of the claim. Together they render us unable to reach any conclusion other than that claimant is not credible.

Most damaging to claimant's claim are the statements she made following the May 1987 automobile accident with Heeter. The fact that she admittedly lied to the emergency room personnel as to who was driving the vehicle and what caused the accident is certainly damaging to her credibility. However, her statement to Dr. Conwell regarding the incident is even more damaging. Claimant, in this regard, did not merely falsely assert that she was driving the vehicle. Rather, she fabricated a host of symptoms which supposedly led to the accident. Some of these symptoms are the same symptoms which she associates with her alleged headaches.

When combined with claimant's conviction for filing a false police report, and the events involved in the felony charge of hindering prosecution, we are unable to reach any conclusion other than that claimant is not credible. Moreover, claimant's credibility is particularly crucial in a case such as this one where objective evidence of impairment is lacking.

Claimant's lack of credibility not only renders her own testimony unpersuasive, but it also renders the opinions of Dr. Conwell unpersuasive. This conclusion results from the fact that Dr. Conwell's conclusions are valid only to the extent that the underlying bases of those opinions are accurate and truthful. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Further, there is no indication in Dr. Conwell's reports that he was aware of the repeated physical abuse claimant was subjected to by her ex-husband. Consequently, he offers no opinion as to what role that physical abuse played in the cause or continuation of claimant's headaches.

In sum, after rejecting claimant's own testimony and the opinions of Dr. Conwell, no persuasive evidence supports claimant's claim to permanent disability.

Aggravation

Claimant's aggravation claim suffers from the same infirmity as does her claim to permanent disability. To wit, no credible evidence supports her claim of a worsening. Therefore, the aggravation claim must also fail.

ORDER

The Referee's order dated October 1, 1987 is affirmed.

GLORIA SERNA, Claimant
Myrick, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-11974
October 10, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Blevins' order that: (1) affirmed a Determination Order that awarded temporary total disability and 15 percent (48 degrees) unscheduled permanent disability for a low back injury; (2) upheld the self-insured employer's denial of claimant's medical services claim for a cervical and thoracic back condition; and (3) upheld the employer's denial of claimant's aggravation claim for her current low back condition. The employer cross-requests review of those portions of the Referee's order that: (1) set aside its denial of claimant's current psychiatric condition; and (2) set aside its denial of chiropractic treatments for claimant's current low back condition. We affirm in part, reverse in part, and modify in part.

ISSUES

The issues are compensability of claimant's psychiatric condition and compensability of chiropractic treatments for claimant's current low back condition.

FINDINGS OF FACT

Claimant, 29 years of age at hearing, compensably injured her low back in 1984. She was treated conservatively by Dr. Samuels, chiropractor, and by Dr. Campagna, neurologist. A myelogram and CT scan requested by Dr. Campagna were essentially normal.

Dr. Samuel recommended psychological counseling for claimant in March, 1985. Claimant was reviewed for admission to a pain center by Dr. Daskalos, D.O., who diagnosed acute and chronic lumbar strain, with myofascial syndrome and probable psychological factors. Dr. Hennings, the pain center's psychologist, reported long-standing hypochondriasis and narcissistic personality disorder.

Dr. Samuel reported in July, 1985, that claimant would have no permanent impairment as a result of her low back condition.

A Determination Order issued September 13, 1985, awarding claimant temporary total disability from the date of injury to August 16, 1985. In addition, claimant was awarded 15 percent unscheduled permanent disability for her low back condition.

Claimant was injured in a motor vehicle accident on February 18, 1986. She suffered injuries to her cervical and thoracic back. Following the motor vehicle accident, Dr. Samuel treated her for spinal axis sprain/strain with myofascitis.

On June 25, 1986, the claims administrator issued a partial denial which denied further treatment as not reasonable and necessary and which denied the compensability of "your current treatment."

On August 17, 1986, Dr. Samuel reported that the

February, 1986, motor vehicle accident had exacerbated claimant's low back condition, which had been stationary. He reported there was permanent impairment from the industrial injury.

Prior to the February, 1986, motor vehicle accident, claimant had worked with her husband, a self-employed house painter.

ULTIMATE FINDINGS OF FACT

Claimant's compensable injury is a material contributing cause of her present psychiatric condition.

Claimant's compensable injury is a material cause of her need for chiropractic treatment in 1986.

OPINION

We adopt the Referee's "Opinion" on all issues except the issue of the compensability of claimant's chiropractic care with the following supplementation.

Psychiatric Condition

The Referee found that claimant had proved a compensable psychiatric condition requiring medical services. The employer, relying on Dr. Parvaresh's report, asserts that claimant's psychiatric condition preexisted her industrial accident and is independent of it.

To establish the compensability of her psychiatric condition as a compensable consequence of her low back injury, claimant must prove that her low back condition was a material contributing cause of the need for treatment. See Grace v. SAIF, 76 Or App 511 (1985); Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987)

Dr. Howell, D.O., reported on August 15, 1985, that there was no objective basis for claimant's low back pain and right leg pain. He felt her pain was psychogenic and not related to her industrial injury.

Claimant told Dr. Parvaresh, psychiatrist, that she suffered from anxiety and headaches for some time prior to the industrial injury. Dr. Parvaresh found no evidence of a psychotic disorder and opined that her psychiatric condition was not related to her compensable injury.

Dr. Kirkpatrick, psychiatrist, reported that claimant suffered from chronic, sub-acute depression based on narcissistic, passive-dependent, and hypochondriacal defenses. He opined that this condition had been aggravated by claimant's compensable injury and recommended psychotherapy.

Dr. Hennings agreed with Dr. Parvaresh that claimant has a maladaptive personality disposition which is independent of her industrial injury. However, he felt her continued somatization and excessive pain behavior suggest that her compensable injury

had exacerbated and made materially worse an underlying personality disposition towards somatization of anxiety. He recommended psychotherapy and opined that there were no permanent residuals from this condition.

In reviewing the reports of Drs. Parvaresh, Hennings, and Kirkpatrick, we note that even Dr. Parvaresh's report notes increased symptoms of the diagnosed psychiatric conditions. His conclusion, however, is that claimant's psychiatric condition is not related to her compensable injury. Neither Dr. Parvaresh nor Dr. Kirkpatrick address the other stressors that could contribute to claimant's symptoms.

Dr. Hennings' report addresses other stressors in claimant's life, such as marital problems, financial stress, and her spouse's business problems. He concludes, nonetheless, that claimant's low back injury contributes to her need for psychotherapy. We find this report to be most persuasive because it discusses the other emotional stressors in claimant's life as opposed to just her compensable injury. We agree with the Referee's conclusion that claimant's current psychiatric condition is compensable.

The Employer's Denial of Current Medical Services

On November 22, 1985, in addition to denying claimant's psychiatric condition, the employer also denied claimant's current chiropractic treatments. The employer contended that the treatments were not reasonable and necessary. The Referee disagreed and set aside the employer's denial in its entirety. As previously discussed, we agree with the Referee that claimant's current psychiatric condition is compensable. However, we are not persuaded that the disputed chiropractic treatments are reasonable and necessary.

Dr. Samuel, the treating physician, indicates that the compensable injury remained a material cause of claimant's low back condition after the motor vehicle accident; he does not voice an opinion whether chiropractic treatment is reasonable and necessary treatment for the compensable injury. On the other hand, Dr. Howell reports that claimant was unable to identify any benefit she was receiving from the treatment. He opined that the treatment was not reasonable and necessary. We defer to Dr. Howell's opinion. Accordingly, claimant has failed to sustain her burden of proving that the chiropractic treatment was reasonable and necessary. That portion of the Referee's order that set aside the aforementioned portion of the employer's November 22, 1985 denial is reversed.

As a result of this decision, claimant has not finally prevailed against the entirety of the employer's denial. Therefore, we modify the $2,000 attorney fee awarded by the Referee to claimant's attorneys for prevailing against the denial. After considering the factors listed in OAR 438-15-010(6), we conclude that $1,200 is a reasonable fee for prevailing against that portion of the employer's denial which pertained to claimant's current psychiatric condition.

Claimant has also prevailed on Board review against the employer's challenge to the Referee's decision concerning the psychiatric condition. Such circumstances generally would entitle

claimant to a carrier-paid fee. ORS 656.382(2); Kordon v. Mercer Industries, 308 Or 290 (1989). However, claimant has not submitted a brief on review. Under such circumstances, claimant is not entitled to an attorney fee. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated September 18, 1987, is affirmed in part, reversed in part, and modified in part. That portion of the Referee's order that set aside that portion of the denial of November 22, 1985 which denied that current medical treatment was reasonable and necessary are reversed. The aforementioned portion of the employer's denial is reinstated and upheld. The Referee's attorney fee award is modified from $2,000 to $1,200. The balance of the Referee's order is affirmed. A client-paid fee, not to exceed $1,793.43, is approved.

ROGER W. SMALL, Claimant
ROGER D. BENNETT, Claimant
JAMES J. FRANKLIN, Claimant
W.D. Bates, Attorney
Coons & Cole, Attorneys
Dennis Ulsted (SAIF), Defense Attorney
Acker, Underwood, et al., Defense Attorneys

WCB 85-04022, 85-03590 & 85-03591
WCB 84-13561 & 84-13562
WCB 85-05679 & 85-05678
October 10, 1989

Reviewed by Board Members Howell and Speer.

The Workers' Compensation Department requests review of Referee Mills' order which: (1) set aside the SAIF Corporation's denial of responsibility on behalf of the noncomplying employer, Rainbow Roofing; and (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility. On review, the issue is whether SAIF is responsible for the three claims or whether Liberty Northwest is responsible by virtue of former ORS 656.029. We reverse.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Liberty Northwest's insured "let a contract" with Rainbow Roofing.

CONCLUSIONS OF LAW

1983 or 1985 Version of ORS 656.029(1)

In 1985, the legislature amended ORS 656.029(1) by limiting its application to situations involving the performance of labor "where such labor is a normal and customary part or process of the person's trade or business * * *". The 1983 version did not contain such language.

Liberty Northwest argues that the Board should apply the 1985 version of ORS 656.029(1). This version was enacted on September 20, 1985. The three claims all arose between October 31, 1984 and November 7, 1984. Therefore, if the 1985 version of ORS 656.029(1) were applicable, it would have to be applied

retroactively. The Referee declined to apply the 1985 version of this provision retroactively and we agree. See Joseph M. Doolittle, 41 Van Natta 211, 213 (1989). We, therefore, apply the 1983 version of ORS 656.029(1) which was in effect at the time the three claims arose.

Responsibility

The Referee concluded that Liberty Northwest's insured was not responsible for the three claims as it did not "let a contract" as that phrase is use in the 1983 version of ORS 656.029(1). We disagree.

The 1983 version of ORS 656.029(1) provided:

> "If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract is let, with assistance from others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let is qualified either as a carrier-insured employer or a self-insured employer."

This statute was designed to protect employees from uninsured subcontractors and place ultimate responsibility on a principal contractor who has the ability to : (1) choose the subcontractor; (2) insist upon appropriate compensation protection; and (3) pass on the responsibility of coverage. E.W. Eldridge, Inc. v. Becker, 73 Or App 631 (1985). "Letting a contract" connotes the situation where bids are normally received and the contract is awarded to the lowest responsible bidder. Dennis P. Cummings, 36 Van Natta 260, 262 (1984). Further, it is the nature of the agreement, rather than the nature of the primary's business, that is the controlling factor in applying the "lets a contract" language in former ORS 656.029(1). Todd A. Aucone, 37 Van Natta 552, 554 (1985).

Liberty's Northwest's insured was a person engaged in business and subject to ORS Chapter 656. Unlike the situation in Cummings, supra, wherein the Board held that former ORS 656.029(1) did not apply, here Liberty Northwest's insured called for and received three bids from three different roofers. Moreover, after consulting persons who had previously employed Rainbow Roofing, Liberty's insured entered into a written agreement with Rainbow Roofing. Under these circumstances, we conclude that a "contract was let" pursuant to the 1983 version of ORS 656.029(1).

Our conclusion is supported by the plain and unambiguous reading of former ORS 656.029(1). The 1983 version of this provision does not contain the delimiting language that was added in 1985. Accordingly, by operation of that provision, Liberty's insured is deemed responsible for the three claims at issue.

ORDER

The Referee's order dated March 7, 1988, is reversed.

The SAIF Corporation's denial is reinstated and upheld. Liberty Northwest Insurance Corporation's denial is set aside and the claims are remanded to it for processing according to law.

HIPALITO SUAREZ, Claimant
Emmons, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-02110
October 10, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee Foster's order that: (1) set aside its partial denials of claimant's ongoing chiropractic care; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 25 percent (80 degrees), as previously awarded by a Determination Order, to 40 percent (128 degrees). On review, the issues are medical services and the extent of permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was 30 years of age at hearing. He compensably injured his low back in May, 1986. A CT scan showed no objective findings. He was treated conservatively by a chiropractor and neurologist, and returned to work briefly. His treating chiropractor, Dr. Boyer, took claimant off work in July, 1986, and continued twice weekly treatments.

Claimant was examined by Dr. Burke, chiropractor, on December 22, 1986. Dr. Burke diagnosed an annular tear of the L4-5 disc. He reported that claimant was medically stationary and had reached maximum benefit from chiropractic care. He advised against further chiropractic manipulation of claimant's back to prevent further injury to the L4-5 area.

On January 14, 1987, the insurer issued a partial denial, denying ". . . any further chiropractic treatment."

On April 9, 1987, claimant was examined by Dr. Duncan, chiropractor. He diagnosed an "overuse" strain, long resolved. He reported that further treatment was not needed.

On August 17, 1987, the insurer issued a clarification of its previous partial denial, again denying further chiropractic care.

ULTIMATE FINDINGS OF FACT

As a result of his work activities, claimant has suffered permanent impairment in the minimal to mild range.

The insurer's denials denied further chiropractic care beyond the date of the denials. There is no evidence in the record establishing the existence of denied medical services claims at issue at the time of hearing.

CONCLUSIONS OF LAW AND OPINION

Extent of permanent disability

Claimant was awarded 25 percent unscheduled permanent disability by Determination Order. The Referee increased this to

40 percent. We believe claimant was appropriately compensated by the Determination Order.

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in former OAR 436-30-380, et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

The medical evidence here indicates claimant's impairment is in the minimal to mild range. The Referee did not give much weight to claimant's treating chiropractor's opinion that claimant's permanent disability is in the moderate range. We agree with that assessment. Instead, we find the report of Dr. Burke to be persuasive regarding claimant's permanent impairment. He opined that claimant's compensable injury would result in some residuals, and reported 5-10 percent impairment.

Claimant has the equivalent of a 6th grade education and has limited transferable skills. He speaks basic English only. However, the weight of the medical evidence indicates claimant could return to his former work or similar work. After reviewing the relevant factors, we find that an award of 25 percent unscheduled permanent disability appropriately compensates claimant for permanent loss of earning capacity. We therefore reverse the Referee's award and affirm the Determination Order.

Partial denial of chiropractic care

The January 14, 1987 partial denial, and the clarifying denial letter of August 17, 1987, both deny "further chiropractic care." The Referee found that Dr. Boyer's treatment was reasonable and set aside both denials. He further ordered that claimant continue to receive two chiropractic treatments per month.

A partial denial denying all further chiropractic treatment denies prospective treatment and is invalid. See Robert M. Bryant, 41 Van Natta 324 (1989); Arlene S. Pettit, 40 Van Natta 1610 (1988). The Referee only has jurisdiction to uphold or set aside denied medical services claims. There are no denied medical services claims in this record. Therefore, we affirm that portion of the Referee's order setting aside the insurer's prospective denials.

In addition, neither party raised the issue of the frequency of treatment at hearing. Therefore, we conclude that the Referee's frequency ruling was procedurally improper. Since the issue was not raised, we make no judgment as to the reasonableness or necessity of current treatment and we disavow the Referee's gratuitous finding concerning future treatment. See Sammy D. Murphy, 41 Van Natta 516 (1989).

ORDER

The Referee's order dated November 20, 1987, is affirmed in part and reversed in part. That portion which awarded claimant

40 percent (128 degrees) unscheduled permanent disability, in lieu of and not in addition to the 25 percent (80 degrees) awarded by the Determination Order is reversed. The Determination Order award is reinstated and affirmed. The remainder of the Referee's order is affirmed. For services on Board review concerning the medical services issue, claimant's attorney is awarded an assessed fee of $400, to be paid by the insurer. A client-paid fee, not to exceed $1704, is approved.

RANDY R. WESTFALL, Claimant
Vick & Gutzler, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 88-01147
October 10, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Schultz's order that set aside its medical services denial. On review, the issue is the compensability of claimant's current need for medical services. We reverse.

FINDINGS OF FACT

Claimant, 32 at the hearing, compensably injured his low back in January, 1986. The insurer accepted his claim as a nondisabling injury. A few days later, he was examined by Dr. Ellerbrook, his family physician. Ellerbrook diagnosed a low back strain and referred claimant to Dr. Keiser, M.D., for four weeks of physical therapy. After performing a closing examination on July 15, 1986, Keiser found that claimant's low back was medically stationary and without permanent impairment.

Although claimant took no time off work following his compensable injury, his low back pain continued. He also began to experience pain in his mid-and-upper back. In July, 1987, his pain increased while playing softball. A week later, he sought treatment from Dr. Haagen, a chiropractor. Haagen diagnosed a "strain/sprain" of claimant's entire back and began daily chiropractic adjustments.

In September, 1987, claimant changed jobs. His new job required prolonged driving throughout the State of Oregon, which increased his back pain.

Claimant was examined by Dr. Duncan, a chiropractor, in November, 1987. Duncan found no signs of unresolved ligamentous or muscle strain to warrant chiropractic treatment. According to Duncan, claimant's then current back pain was related to a preexisting lumbosacral "facetal tropism."

In December, 1987, the insurer issued a denial of claimant's current need for medical services.

In response to Dr. Duncan's opinion, Dr. Haagen authored a report of February 24, 1988, wherein he, inter alia, explained that claimant's unresolved low back condition had resulted in thoracic and cervical complications. He agreed, however, that claimant had congenital "facetal tropism."

In a report dated March 9, 1988, Dr. Miller, a chiropractor who had previously examined claimant on referral from Dr. Haagen, corroborated Haagen's diagnosis of a sprain/strain throughout the

entire back. Miller offered no opinion concerning the etiology of claimant's then current condition, however. That same day, claimant was examined by the Independent Chiropractic Consultants ("Consultants"). The Consultants found, inter alia, signs of "facetal tropism", Ex. 11-4, and concluded that claimant's then current chiropractic treatments were not related to his January, 1986, compensable injury.

CONCLUSIONS OF LAW

A worker is entitled to medical services for conditions resulting from the compensable injury for such period as the nature of the injury or the process of recovery requires. ORS 656.245(1). Finding that this is "not a complicated case requiring expert medical analysis," the Referee concluded that claimant had proven compensability based solely on his "credible testimony." We disagree.

Claimant sustained a nondisabling low back strain in January, 1986. After a brief course of physical therapy, Dr. Keiser declared him medically stationary and without permanent impairment. No further medical treatment was sought or rendered until July, 1987, i.e., one year later, when claimant consulted Dr. Haagen. Haagen was the first medical expert to diagnose anything other than a low back strain. Moreover, there is no dispute among the medical experts that claimant has a preexisting lumbosacral "facetal tropism."

Under such circumstances, we conclude that the causation of claimant's current back condition presents a complex medical question. Hence, although claimant's testimony is certainly probative, the resolution of this case largely turns on the weight of the medical opinions. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

When the medical opinions are divided, as here, we must choose the correct medical hypothesis. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 416 (1986). Dr. Haagen opines that claimant's current spinal complaints are causally related to his January, 1978, compensable injury. Accordingly, Haagen reported, inter alia:

> "Concerning the history of the [claimant's] spinal condition, it would appear as though the [claimant's] original complaint was isolated to the low back area. But due to the condition being unresolved it gradually worsened and ultimately caused secondary complications affecting the thoracic and cervical regions. Such a sequence of events is not uncommon concerning back-related conditions." (Ex. 9).

We are not persuaded by Dr. Haagen's opinion. First, he does not explain how, or by what mechanism, claimant's unresolved low back strain "caused secondary complications" in his mid-and-upper back. Second, he does not dispute Dr. Duncan's finding of preexisting lumbosacral "facetal tropism." Last, he does not persuasively rebut Duncan's hypothesis that the "facetal tropism" is the cause of claimant's current back pain.

Dr. Duncan and the Consultants disagree with Dr. Haagen. Their opinions are both well-reasoned and based on a complete and accurate medical history. Accordingly, Duncan reported, inter alia:

"[T]he radiographic evidence documents a lumbosacral facetal tropism * * * . There is no objective evidence that the January 1986 incident caused, or materially contributed to this undoubtedly pre-established condition. I believe that his current low back complaints and associated treatment are directly related to this pre-established situation, which is aggravated by increased activities or compromised postures, either on or off the job." (Ex. 7-6).

Duncan's opinion was corroborated by the Consultants.

In sum, we are persuaded by the collective opinions of Dr. Duncan and the Consultants, over that of Dr. Haagen. Although we have considered claimant's credible lay testimony of continuing low back pain that gradually migrated to his mid-and-upper back, on this record, the preponderance of the evidence does not establish that the January, 1986, compensable injury is a material contributing cause of claimant's current back condition.

ORDER

The Referee's order, dated April 25, 1988, is reversed. The insurer's medical services denial is reinstated and upheld. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $2,442.50.

STANLEY E. WRIGHT, Claimant
Michael B. Dye, Claimant's Attorney
Phil Garrow, Claimant's Former Attorney
Marcus K. Ward, Defense Attorney

WCB 87-03493, 87-03494 & 87-07758
October 10, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of that portion of Referee Gruber's order that: (1) set aside SAIF's denial of claimant's occupational disease claim for degenerative conditions of the back and neck; and (2) upheld SAIF's denial, as processing agent for the noncomplying employer, for an injury to the back and neck. Claimant cross-requests review of that portion of the order that awarded claimant no temporary disability for the period following April 17, 1987. The issues on review are compensability of an occupational disease, responsibility, and temporary disability. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" in the Referee's order and make the following additional findings:

Following the incident of October 2, 1986, claimant did not seek medical treatment for an injury to his back and neck until January 2, 1987.

Claimant's neck and back condition came on gradually during the years of his employment with the employer.

FINDINGS OF ULTIMATE FACT

The incident of October 2, 1986 caused pain, but did not cause disability or require medical services.

Claimant's work activity for the employer was the major contributing cause of his degenerative neck and back conditions, which resulted in a need for treatment.

Claimant became disabled due to the degenerative neck and back conditions on January 2, 1987.

CONCLUSIONS OF LAW

Compensability

The Referee concluded that the condition requiring medical services on January 2, 1987 was an occupational disease rather than an injury. We agree. The condition for which claimant was treated in 1987 was a degenerative condition, which was the result of many years of occupational exposure to strenuous bending, stooping, lifting and overhead work. It did not develop as a result of the October 2, 1986 incident. It was neither sudden in onset nor unexpected. Therefore, it was an occupational disease. James v. SAIF, 290 Or 343 (1981).

Like the Referee, we rely on Dr. Newby's opinion that claimant's back and neck pain was caused by degenerative changes, which were caused by claimant's work activities. There being no contrary medical evidence in the record, and Dr. Newby's being persuasive, we have concluded that the major contributing cause of claimant's condition is work activities and therefore that the occupational disease claim is compensable.

The Referee held that claimant's injury claim for the October 2, 1986 incident was not compensable because it was not "anything more than a mild, temporary exacerbation of a problem which had been ongoing for a number of years." He concluded that the injury did not independently contribute to a worsening of claimant's underlying condition or to the worsening of symptoms for which the claimant received medical treatment. Independent contribution to a worsening of an underlying condition is not the test for compensability of an injury. It is sufficient that an injury exacerbate symptoms of a preexisting condition. Grace v. SAIF, 76 Or App 511 (1985). Nevertheless, the injury did not result in a compensable injury because it caused no disability or need for treatment. ORS 656.005(7)(a). For that reason, we affirm on the issue of compensability.

Responsibility

The Referee assigned responsibility for claimant's compensable occupational disease to SAIF, the insurer on the risk on and after October 21, 1986. It appears that the Referee assigned responsibility to SAIF because SAIF was on the risk on December 26, 1986 when the claim was filed. The result is correct, but the analysis faulty.

Responsibility rest, in the first instance, with the insurer on the risk at the onset of disability if work conditions with that employer could have contributed to the disability. If a later employment independently contributes to a worsening of the disease,

responsibility shifts to the subsequent employer. Bracke v Baza'r, 293 Or 239 (1982); Spurlock v. International Paper Co., 89 Or App 461, 465 (1988).

We have found that claimant became disabled on January 2, 1987 because there is no evidence that claimant was unable to work due to the compensable condition until that date. At that time, Dr. Newby indicated that claimant was unable to work due to the neck and back condition. SAIF was on the risk on January 2, 1987, and there was no worsening of the disease as the result of a later employment. Accordingly, SAIF is responsible for the condition.

Temporary Total Disability Compensation

The Referee denied claimant temporary disability compensation for the period following his refusal to accept light work on April 16, 1987. We affirm, but again on different grounds.

The Referee concluded that, following April 16, "claimant had the capacity to earn exactly the same wage which he was earning at the time he became disabled." For that reason, he concluded that under ORS 656.212 no temporary disability compensation was due. In the absence of a finding that claimant was in fact medically stationary and able to perform regular work on April 16, we do not believe that an abstract ability to earn what could have been earned pre-injury supports an insurer's failure to pay temporary disability compensation prior to claim closure.

Nevertheless, the insurer's conduct in this case was proper under OAR 436-60-030(5). The rule entitles the insurer to deduct from temporary disability otherwise due, wages which claimant would have earned performing light work if the insurer notifies the attending physician of the specific duties involved and the physical requirements of them, the attending physician indicates that the duties are within claimant's capacities, and the employer has notified claimant in writing of the job opportunity as required by the rule. SAIF did all these things. (Ex. 46A, 38.) The offer contemplated that claimant would be paid his pre-injury wage. The claimant rejected the offer of work. Therefore, SAIF was entitled to treat claimant as if he were earning the offered wages. Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986). Thus, the Referee did not err in declining to award temporary disability compensation for the period after April 17, 1987.

ORDER

The Referee's order dated October 21, 1987, is affirmed. For services on Board review, claimant's attorney of record, the firm of Michael B. Dye, is awarded a reasonable assessed fee of $750, to be paid by the SAIF Corporation. A client-paid fee, not to exceed $360, payable by SAIF to its outside counsel for the noncomplying employer, is approved.

JOHN W. CHURCH, Claimant
Myrick, Coulter, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
Brian Pocock, Defense Attorneys

WCB 86-18198 & 86-06319
October 11, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Mission Insurance requests review of Referee Brown's order which: (1) set aside its denial of claimant's claim for a low back condition; (2) upheld Aetna's denial of the same condition. Additionally, Mission requests that we remand the case to the Referee for joinder of additional parties. On review, the issues are timeliness, compensability, responsibility and remand. We affirm the Referee and decline to remand the case.

FINDINGS OF FACT

We adopt the Referee's "Findings."

FINDINGS OF ULTIMATE FACT

The traumatic incident in December 1983, occuring while claimant was employed at Mission's insured, caused the spur and compression fracture at T12, and L1, respectively. Claimant's subsequent work activities for Aetna's insured did not independently contribute to a worsening of these conditions.

Claimant's work activities, while at Mission's insured, were the major contributing cause of the worsening of his L5-S1 degenerative disc condition. Claimant's subsequent work activities for Aetna's insured did not cause or worsen this degenerative condition.

The record has not been improperly, incompletely, or insufficiently developed.

CONCLUSIONS OF LAW

We adopt the conclusions of law as set out in the "Opinion" section of the Referee's order with the following supplementation.

Mission contends that this matter should be remanded first on the basis that all parties were not joined and second, that the Referee indicated he would not decide the responsiblity issue.

In regard to remand on the basis that further parties need to be joined, we are not persuaded by Mission's argument for the following reasons.

Affidavits from the Compliance Division indicate that Mission's insured was insured subsequently by other insurance companies. Despite this fact, Mission did not move to join the other companies prior to the hearing. Mission would apparently have us remand for a joinder of these companies in order to shift responsibility for claimant's condition on the basis that his work while these insurers were at risk independently contributed to his condition. This result, however, was rejected by the Supreme Court in Runft v. SAIF, 303 Or 493 (1987). Accordingly, we decline to remand the case on this basis. See James L. Lance, 39 Van Natta

1033, 1153 (1987), Aff'd mem Peter Kiewit & Sons v. R. A. Gray Co., 92 Or App 591 (1988).

In regard to Mission's second basis for remand, we agree that the Referee suggested at the hearing that he would not decide responsibility. Yet, the insurers' denials placed responsibility squarely at issue. Moreover, the manner in which the Referee decided compensability necessarily decided the responsibility issue as well. Under these circumstances, we are not persuaded that this record has been "improperly, incompletely or otherwise insuffciently developed." See ORS 656.295(5). Consequently, Mission's motion for remand is denied.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated July 21, 1987, is affirmed. A client-paid fee, not to exceed $313, is approved, payable by Mission Insurance to its counsel. A client-paid fee, payable from Aetna to its counsel, is approved, not to exceed $295.

MICHAEL A. GRIGGS, Claimant
Roll, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Roy Miller (SAIF), Defense Attorney
Nelson, et al., Defense Attorneys

WCB 88-04104, 88-03394 & 88-03395
October 11, 1989
Second Order Denying Reconsideration

Liberty Northwest Insurance Corporation seeks withdrawal and reconsideration of our July 19, 1989 Order on Review that affirmed a Referee's order which set aside its denial of claimant's "new injury" claim for a low back condition. Specifically, Liberty Northwest repeats an earlier request that we take administrative notice of "admissions by claimant before a Referee" in a subsequent hearing or, alternatively, that we remand to the Referee for the taking of additional evidence not obtainable at the previous hearing. Liberty Northwest's prior request was denied by an evenly divided Board on August 14, 1989.

On August 16, 1989, Liberty Northwest filed its petition for judicial review of our July 19, 1989 order with the Court of Appeals. See ORS 656.298(3). Thus, jurisdiction to consider this matter vested with the Court of Appeals upon the filing of Liberty Northwest's appeal. See Pedro G. Alcala, 39 Van Natta 1161 (1987).

It is possible to withdraw and reconsider an order after the filing of a petition for judicial review with the Court of Appeals. ORS 183.482(6); Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Under these circumstances, we conclude that the appropriate forum to consider the issues raised in this dispute is the Court of Appeals. Consequently, we decline to withdraw our July 19, 1989 Order

on Review. 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), rev den 300 Or 605 (1986).

IT IS SO ORDERED.

GARY G. LEGLER, Applicant
Thomas J. Dzieman, Assistant Attorney General
Thomas E. Ewing, Assistant Attorney General

WCB CV-89001
October 11, 1989
Order Denying Reconsideration
(Crime Victim Act)

Applicant and the Department of Justice Crime Victims' Compensation Fund ("Fund") have requested reconsideration of the special hearings officer's proposed order issued September 13, 1989, as reconsidered September 27, 1989. The Fund contends that applicant was not the victim of a compensable crime because, pursuant to the findings in the proposed order, he was engaged in a "mutual assault."

The Fund's request does come within 20 days of the proposed order as directed by that order. However, the Fund did not raise the legal defense of "mutual assault" prior to or at hearing despite the existence of facts reasonably giving rise to the issue. Consequently, we decline to address the issue for the first time on reconsideration.

Applicant's request indicates a general dissatisfaction with the proposed order. We have previously reconsidered the special hearings officer's proposed order at applicant's request. We decline to reconsider the order a second time.

In any event, with regard to both requests, had we reconsidered the matter further, we would adhere to our prior Order on Reconsideration which affirmed the proposed order in its entirety.

Accordingly, this matter is final by operation of law. ORS 147.155; OAR 438-82-050(1), (2). There is no further right of appeal. Id.

IT IS SO ORDERED.

JUDY M. MARTIN, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Stoel, Rives, et al., Defense Attorneys

WCB 87-08839
October 11, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Podnar's order that dismissed her request for hearing concerning payment of chiropractic billings. No briefs were filed on review. We affirm.

ISSUES

1. Jurisdiction.

2. Payment of chiropractic billings.

3. Penalties and attorney fees.

FINDINGS OF FACT

Claimant compensably injured her low back on December 4, 1980. Her claim was initially closed with awards totalling 20 percent unscheduled permanent disability.

In approximately November 1983, claimant moved to Oklahoma, where she initially treated with Dr. Freede. In April 1985, she began treating with Dr. Toghi, chiropractor. Dr. Toghi treated claimant 33 times between April 15, 1985 and November 13, 1985.

On November 19, 1985, the employer issued a denial of chiropractic treatments rendered after the date of the denial. Claimant requested a hearing on the denial.

The employer received its first billing from Dr. Toghi on December 9, 1985 in the amount of $2,200.

On January 14, 1986, the employer issued a second denial of chiropractic treatment. On January 16, 1986, the employer paid $1,280.28 to Dr. Toghi.

Claimant discontinued treating with Dr. Toghi in February 1986, when she had unrelated surgery.

On August 21, 1987, the employer paid $155.18 to Dr. Toghi.

By Referee's order dated August 25, 1986, the employer's two denials were set aside. The claim was remanded to the employer for payment of benefits. The employer requested Board review of the Referee's order. On review, the Board affirmed.

The employer paid an additional $31.04 to Dr. Toghi on October 27, 1987, in response to a bill for $60.

ULTIMATE FINDINGS OF FACT

The employer paid benefits as directed by prior order.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing at the conclusion of claimant's case in chief on the basis that claimant had failed to prove that any of Dr. Toghi's fees were due and payable. Alternatively, citing Haynes v. Weyerhaeuser Co., 75 Or App 262 (1985), the Referee found that the matter involved a medical fee dispute within the exclusive jurisdiction of the Director of the Workers' Compensation Department (now Director of the Department of Insurance and Finance).

The Referee accepted the testimony of the employer's claims representative, that Dr. Toghi's bills had been fully paid after adjustment to reflect the limitation on payment of medical bills reflected in former ORS 656.248. Prior to amendment in 1985, ORS 656.248 provided that payment of medical fees shall not exceed the 90th percentile of usual and customary fees as established by the Director. (Pursuant to Or Law 1985, ch 107, effective January 1, 1986, payment was reduced to the 75th percentile of usual and customary fees.) We agree with the Referee that the employer paid

benefits as required by the prior order, and we adopt the Referee's bench decision at Tr. 23.

Claimant contends, however, that the employer's medical payments were inadequate even after allowing for reduction pursuant to former ORS 656.248. We agree with the Referee that this matter involves a dispute as to the appropriate amount of payment of Dr. Toghi's fees for services in connection with claimant's accepted claim. Consequently, jurisdiction over this dispute rests exclusively with the Director. ORS 656.704(3); Haynes v. Weyerhaeuser Co., supra. Accordingly, the Referee properly dismissed claimant's request for hearing.

ORDER

The Referee's order dated December 10, 1987 is affirmed.

HERBERT K. TRACHSEL, Claimant
James K. Gardner, Claimant's Attorney
Beers, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-03027 & 87-03026
October 11, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

EBI Companies requests review of Referee Wilbur C. Smith's order that: (1) found claimant had good cause for failing to request a hearing within 60 days of its denial of claimant's aggravation claim for his current back condition; (2) set aside EBI's denial; and (3) upheld Alexsis Risk Management's denial of a "new injury" claim for the same condition. On review, the issues are good cause, compensability, responsibility, and attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant filed an aggravation claim against EBI on October 24, 1986. His wife telephoned someone at EBI regarding the claim on several occasions and wrote EBI a letter urging them to accept the claim. EBI denied the claim on November 24, 1986. Claimant filed a "new injury" claim with Alexsis on October 24, 1986. He received a temporary total disability check from Alexsis about November 24, 1986. On November 28, 1986, claimant's wife wrote EBI to protest the denial and threatened to contact the Workers' Compensation Department and an attorney.

Claimant filed a request for hearing on February 25, 1987.

ULTIMATE FINDING OF FACT

Claimant did not have good cause for not filing a request for hearing within 60 days of the denial.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that claimant's current back condition is an aggravation of his 1983 compensable injury with EBI. We agree. The medical evidence, in particular the report of Dr. Grimm, indicates that claimant's current back condition is not a new injury. Claimant

testified that he suffered ongoing symptoms from the 1983 injury and that the August, 1986 incident increased existing symptoms. We find that the claim is one for aggravation for which EBI would be responsible.

Good cause for untimely filing

The Referee found that claimant had proven good cause for not filing a request for hearing, within 60 days from EBI's denial. He reasoned that claimant had good reason to believe that his claim had been accepted by another insurer. We disagree.

Claimant has 60 days to request a hearing on a denial, or 180 days if good cause for the failure to request within the 60 days is shown. ORS 656.319(1). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, surprise or excusable neglect" recognized under former ORS 18.160 and present ORCP 71B(1). 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). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234 (1985).

EBI denied claimant's aggravation claim on November 24, 1986. Claimant did not file a request for hearing until February 25, 1987. Claimant testified that he was taking several drugs for pain during this period and did not recall events, even as to receiving the denial letter.

Claimant's wife wrote EBI to encourage claim acceptance in October, 1986, and wrote again after receiving the denial letter. In this letter, she indicated she would bring the matter to the attention of the Workers' Compensation Department and possibly an attorney. Claimant's wife also requested an offer of settlement in that letter in exchange for not pursuing legal action. Further, she testified that just after receiving EBI's denial letter, claimant received a check for temporary total disability from Alexsis, which led them to believe Alexsis had accepted the claim. The Referee found that under these facts, claimant had proven excusable neglect.

We conclude that claimant has not met his burden. Claimant argues that his belief that Alexsis had accepted the claim by paying temporary total disability constitutes excusable neglect. However, his wife wrote EBI threatening legal action and demanding settlement after receiving Alexsis' check. The evidence establishes that claimant and his wife were aware of the legal situation and their rights. Claimant's wife was advised to file more than one claim and to file a request for hearing. The actions of claimant's wife, after receiving EBI's denial, are inconsistent with claimant's argument on review. Such actions do not persuade us that claimant believed Alexsis had accepted his claim. See Summey v. Auto Body Specialists, 93 Or App 544 (1988). We find claimant did not have good cause for failing to file his request for hearing within 60 days of the mailing of the denial.

ORDER

The Referee's order dated November 27, 1987 is reversed in part and affirmed in part. That portion which set aside EBI Companies' denial of claimant's aggravation claim is reversed. Claimant's request for hearing from EBI's denial is dismissed as untimely. The remainder of the Referee's order is affirmed. A client-paid fee, payable from Alexsis to its counsel, not to exceed $1,578, is approved.

JOEL D. TURPIN, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Gary Jones, Defense Attorney
E. Jay Perry, Defense Attorney
William Blitz, Defense Attorney

WCB 87-10475, 87-10474 & 87-02844
October 11, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation, on behalf of its insured, Super Trucks, requests review of Referee Baker's order that: (1) set aside its denial of claimant's "new injury" claim for bilateral carpal tunnel syndrome; (2) upheld its denial, on behalf of Salt Springs Logging, of the same condition; (3) upheld Liberty Northwest Insurance Corporation's denial of an aggravation claim for the same condition; and (4) assessed SAIF a carrier-paid attorney fee to be paid to claimant's counsel. The issues on review are responsibility and attorney fees. We affirm and modify.

The Board adopts the order of the Referee with the following supplementation.

We agree with the Referee that claimant's work activities for Super Trucks independently contributed to a worsening of his underlying bilateral carpal tunnel syndrome. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). We further agree that claimant's subsequent work activities with Salt Springs Logging did not independently contribute to a worsening of his underlying condition. Therefore, SAIF, as insurer for Super Trucks, is responsible for claimant's current bilateral carpal tunnel syndrome.

We modify that portion of the Referee's order that assessed SAIF a carrier-paid fee.

SAIF and Liberty Northwest argue that claimant's attorney was not entitled to an attorney fee for participating at hearing. We disagree. All of the insurers agreed by the time of hearing that responsibility was the only contested issue. Yet, no ".307" order issued before hearing because compensability had been denied by Liberty Northwest. Therefore, claimant's entitlement to receive compensation remained at risk. See Dale L. Tichenor, 40 Van Natta 866, on recon 41 Van Natta 179 (1989).

Accordingly, we conclude that claimant's attorney was entitled to an insurer-paid attorney fee under ORS 656.386(1). We further find that Liberty Northwest, the nonresponsible insurer who prevented the issuance of a ".307", order is responsible for claimant's attorney fee for services at hearing. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). The Referee's order shall be modified accordingly.

Finally, a claimant's attorney is entitled to a reasonable fee when a carrier initiates Board review and the Board determines that "the compensation awarded to [the] claimant should not be disallowed or reduced." ORS 656.382(2).

Here, SAIF requested Board review and sought to shift responsibility for claimant's claim to Liberty Northwest. As previously discussed, no order designating a paying agent pursuant

to ORS 656.307 had issued. Consequently, claimant's entitlement to receive compensation remained at risk. See Thomas W. Williamson, 39 Van Natta 1147 (1987). 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 SAIF, the insurer who invited Board review.

ORDER

The Referee's order dated December 3, 1987, is modified. The attorney fee awarded by the Referee shall be paid by Liberty Northwest Insurance Corporation, rather than the SAIF Corporation. A client-paid fee, payable by Liberty Northwest to its counsel, not to exceed $722, is approved. A client-paid fee, payable by SAIF to its outside counsel, not to exceed $1,220, is approved. For services on Board review regarding the issue of responsibility, claimant's counsel is awarded an assessed fee of $300, to be paid by SAIF on behalf of Super Trucks. The remainder of the Referee's order is affirmed.

ELMIRA K. SATCHER, Claimant	WCB 87-03768
Patrick Mackin, Claimant's Attorney	October 11, 1989
Kevin Mannix & Associates, Defense Attorneys	Order on Review

Reviewed by Board Members Nichols and Crider.

The insurer requests review of those portions of Referee Galton's order which: (1) Assessed a penalty for late payment of benefits pursuant to an earlier Opinion and Order; (2) set aside a denial of acupuncture treatment; and (3) Assessed a penalty for an unreasonable denial of the acupuncture treatments. We affirm.

ISSUES

The first issue is whether the insurer is obligated to pay for medical benefits on a claim in which the compensability is still not finally decided.

The second issue is whether claimant has proven by a preponderance of the evidence that acupuncture treatments are reasonable and necessary treatments for her presently compensable condition.

The final issue is whether the insurer's denial of acupuncture treatments was unreasonable.

FINDINGS OF FACT

Claimant filed a claim alleging an industrial injury in February 1985. The insurer denied the claim. Referee Tuhy issued an Opinion and Order on February 11, 1986 setting aside the compensability denial. The Board affirmed Referee Tuhy's order on September 4, 1986. The insurer requested judicial review. (The Court of Appeals upheld the Board's order on the compensability issue after the hearing in this matter; that action does not affect the issue presented herein.)

The insurer denied the compensability of chiropractic treatments on September 3, 1986. Referee Lipton set aside the chiropractic denial by Opinion and Order of January 5, 1987.

Although the insurer paid some of the chiropratic bills, it did not do so within 60 days of Referee Lipton's Opinion and Order. Referee Lipton's order became final by operation of law.

The chiropractor referred claimant to an acupuncturist, who began treating claimant on August 28, 1986. The chiropractor reported to claimant's attorney on November 19, 1986 that she had referred claimant to an acupuncturist. The acupuncture was helping claimant to improve. Claimant's attorney introduced the November 19, 1986 report into the record before Referee Lipton by letter dated November 20, 1986.

The insurer denied the compensability of acupuncture treatment on April 3, 1987. The basis of the denial was that there was a preponderance of medical information that the acupuncture treatment was not necessary. There is no such medical evidence in the record supporting that position.

The acupuncture treatments have helped to decrease claimant's pain from his compensable injury. They are reasonable and necessary treatments.

CONCLUSIONS

The Referee reasoned that because Referee Lipton's order finding the chiropractic treatments compensable became final as a matter of law, the insurer was obligated to begin making those payments within 60 days of that order.

We agree. Although medical services were not required to be paid pending appeal of Referee Tuhy's order (ORS 656.313(4)), when the insurer allowed Referee Lipton's order directing payment of specific services to become final, the duty to pay was absolute. See Georgia Pacific v. Piwowar, 305 Or 494 (1988) (holding that a denial does not suspend the duty to pay pursuant to order).

On review, the insurer argues for the first time that it is not obligated to reimburse the acupuncturist because she failed to justify the treatments as required by OAR 436-10-040(4)(a). We decline to consider that argument. The insurer based its denial not on the regulation, but on the reasonableness and necessity of the acupuncture treatment. It took the same position at hearing. It only raises the regulation as a justification as an afterthought. Because the acupuncturist's compliance or non-compliance with that regulation could require additional and different evidence than that required to prove the reasonableness and necessity of the acupuncture treatment, we decline to consider the insurer's argument that it had no obligation to reimburse the acupuncturist due to non-compliance with the regulation.

On the merits of the reasonableness and necessity of the acupuncture treatments and the reasonableness of the acupuncture denial, we adopt the Referee's conclusions contained under the heading "The partial denial and unreasonableness claims."

ORDER

The Referee's order dated September 14, 1987 is affirmed. Claimant's attorney is awarded a reasonable attorney's fee of $900 for prevailing on the issue of the acupuncture denial, to be paid by the insurer. A client paid fee, not to exceed $408.50, is approved.

ROBERT E. WEBER, Claimant
William Hoelscher, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 87-00888
October 11, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Irving's order that: (1) awarded claimant's attorney a fee of $300 for his efforts in inducing the self-insured employer to rescind its denial of his aggravation claim; (2) rejected his request for a penalty and associated attorney fee for unreasonable denial of his aggravation claim; (3) rejected his contention that his aggravation claim was prematurely closed; and (4) failed to award his attorney a fee out of an award of additional temporary disability compensation. Claimant also contends that the Referee erred in refusing to admit Exhibit 25. The employer cross-requests review of those portions of the Referee's order that: (1) awarded claimant additional temporary disability compensation; and (2) failed to authorize an offset of overpaid temporary disability compensation.

ISSUES

1. The admissibility of Exhibit 25.

2. Attorney fee for inducing the employer to set aside its aggravation denial.

3. Penalty and associated attorney fee for unreasonable denial of claimant's aggravation claim.

4. Premature closure of claimant's aggravation claim.

5. Claimant's entitlement to additional temporary disability compensation on his aggravation claim.

6. Attorney fee out of the increase in claimant's temporary disability compensation.

7. Offset of overpaid temporary disability compensation.

FINDINGS OF FACT

Claimant injured the middle and lower portions of his back on June 26, 1985 in the course of his employment as a firefighter with the City of Salem, a self-insured employer, when the truck on which he was riding collided with an automobile. The employer accepted claimant's claim for the injury and the claim was closed by Determination Order in May 1986 with an award of 10 percent unscheduled permanent partial disability. This award was increased to 25 percent by stipulation approved on September 9, 1986.

On September 12, 1986, claimant returned to work for the City of Salem as an Administrative Assistant in the Parks and Recreation Department. This job required claimant to spend a considerable amount of time operating a computer terminal. Within a week, claimant experienced an increase in mid back pain. He sought treatment from a chiropractor, Dr. Waldman, on September 18, 1986. Claimant's back pain continued to increase and he left work on September 30, 1986.

In a report dated November 10, 1986, Dr. Waldman opined that claimant had sustained a new injury in September 1986 which was unrelated to his compensable June 1985 injury. In a report dated one week later, the Orthopaedic Consultants opined that claimant's back pain in September 1986 was related to his previous industrial injury, but that it did not represent a material worsening of that injury. On November 20, 1986, the employer's adjusting agency issued a denial of the compensability of claimant's September 1986 mid back episode. Claimant retained his attorney on December 4, 1986 and the attorney filed a request for hearing on the employer's denial on January 16, 1987.

Claimant was examined by a panel of the Independent Chiropractic Consultants on January 20, 1987. They opined that claimant's September 1986 mid back episode represented an aggravation of his June 1985 industrial injury, but that claimant had recovered from the aggravation and was medically stationary. By letter dated March 6, 1987, the employer's adjusting agency notified claimant that it was rescinding its November 1986 denial and that the employer would accept the September 1986 mid back episode as an aggravation of his June 1985 industrial injury.

Claimant returned to work on April 1, 1987 as a youth counselor for a new employer, the Mid-Willamette Jobs Council. This position involved general office duties and a considerable amount of driving. Claimant experienced an increase in mid back pain within a few weeks of beginning this employment. By mid May, the pain had increased to the point that claimant was totally disabled. He resigned from his job and resumed treatment with Dr. Waldman. On August 25, 1987, a Determination Order issued closing claimant's September 1986 aggravation claim. The order awarded temporary partial disability for the period from September 19, 1986 through January 20, 1987. In a report dated October 9, 1987, Dr. Waldman stated that claimant continued to be totally disabled as a result of his mid back condition.

The hearing was held on October 28, 1987. At the beginning of the hearing, defense counsel objected to a number of exhibits, including Exhibit 25. Exhibit 25 is a letter from Carol Johnson, claimant's supervisor at the Mid-Willamette Jobs Council, to claimant's attorney. In the letter, Mrs. Johnson recites her observations of claimant's physical condition during his employment with the Council and states that claimant left work because of increased back pain. Mrs. Johnson also stated, apparently in response to an informal request by claimant's attorney, that she would not be able to attend claimant's workers' compensation hearing. Defense counsel objected to Exhibit 25 on hearsay grounds. The Referee took the objection under advisement and proceeded with the hearing.

Dr. Waldman testified at the hearing. He opined that claimant's condition had worsened in May 1987 and that claimant was still not medically stationary at the time of the hearing. He added, however, that claimant was nearing a medically stationary status. The parties agreed to leave the record open to allow the employer to arrange for an independent medical examination of claimant. This examination was carried out on December 15, 1987 by Dr. Thompson, an orthopedic surgeon. Dr. Thompson opined that claimant had been medically stationary when the Independent Chiropractic Consultants examined him on January 20, 1987 and that

claimant was medically stationary at the time of Thompson's examination. He did not address the question of whether claimant's condition had worsened in May 1987.

The Referee issued her order on April 11, 1988. She ruled that Exhibit 25 would be excluded "as being hearsay and not within the exception for medical, surgical and hospital records under ORS 656.310(2)."

FINDINGS OF ULTIMATE FACT

1. Exhibit 25 is not a "vocational report." Claimant did not seek a subpoena to compel the attendance of Mrs. Johnson at the hearing and did not request that she be allowed to testify by some other means.

2. Claimant's attorney had expended minimal efforts on claimant's behalf when the employer rescinded its November 1986 denial.

3. The employer's denial of claimant's September 1986 aggravation claim was not unreasonable.

4. Claimant was not medically stationary when the August 1987 Determination Order issued.

5. The temporary disability compensation issue is moot.

6. Claimant's attorney was instrumental in establishing that claimant was not medically stationary when the August 1987 Determination Order issued.

7. The offset issue is moot.

CONCLUSIONS OF LAW

1. Evidence

The Referee excluded Exhibit 25 "as being hearsay and not within the exception for medical, surgical and hospital records under ORS 656.310(2)." Claimant contends that Exhibit 25 should have been admitted because hearsay is generally admissible in Workers' Compensation proceedings and, in any event, the exhibit falls within the "vocational report" exception of former OAR 438-07-010. We address these arguments in reverse order.

Former OAR 438-07-010 provides:

> "Vocational reports and testimony are admissible as expert opinion evidence, subject to the right of cross-examination, if the referee finds the author or witness to be adequately qualified by training and experience in the area of the employability in question, or if the parties stipulate to the expert's qualifications."

This rule was promulgated to carry out the provisions of ORS 656.287. A reading of that section makes it clear that the rule was intended to apply only to "reports from vocational

consultants employed by governmental agencies, insurers or self-insured employers, or from private vocational consultants, regarding job opportunities, the fitness of claimant to perform certain jobs, wage levels, or other information relating to claimant's employability." ORS 656.287(1). The record in the present case fails to establish that Mrs. Johnson is a "vocational consultant" and, in any event, the information contained in her letter is not of the type contemplated by ORS 656.287 or former OAR 438-07-010. Exhibit 25, therefore, is not admissible as a "vocational report."

As for claimant's other argument, he is correct in stating that hearsay evidence is generally admissible in workers' compensation proceedings. Armstrong v. SAIF, 67 Or App 498, 501 n.2 (1984); Marion R. Webb, 37 Van Natta 750, 751 (1985). Such evidence may be excluded, however, when it is in the interests of substantial justice to do so. See former ORS 656.283(7). In the present case, we conclude that the interests of substantial justice warrant exclusion of Exhibit 25. The exhibit contains statements about disputed facts from a lay witness who was not subject to cross-examination by the employer. Claimant made no attempt to compel the attendance of this witness at the hearing or to arrange for her to testify by some other means such as by telephone or deposition. Under these circumstances, we conclude that Exhibit 25 was properly excluded from the record. Cf. OAR 438-07-022 (adopted subsequent to the hearing in this case).

2. Attorney Fee Relating to the Aggravation Denial

The Referee awarded claimant's attorney $300 for inducing the employer to rescind its denial of his aggravation claim. Claimant contends that this fee is inadequate. Before the employer rescinded its denial, claimant's attorney efforts were limited to filing a request for hearing on the denial and reviewing a response filed by defense counsel. We conclude that the fee awarded by the Referee was adequate compensation for these efforts.

3. Penalty and Attorney Fee for Unreasonable Denial of Claimant's Aggravation Claim

Claimant contends that the employer's denial of his aggravation claim was unreasonable and entitles him to a penalty and associated attorney fee under ORS 656.262(10). We disagree. At the time of the denial, the employer had received a report from the Orthopaedic Consultants which indicated that the September 1986 exacerbation of claimant's mid back condition did not represent a material worsening of the condition considering claimant's previous awards of permanent partial disability. Although claimant's mid back exacerbation has been accepted as a worsening within the meaning of ORS 656.273, the employer's denial was not unreasonable under the interpretation of ORS 656.273 current at the time the denial issued. See International Paper Co. v. Turner, 84 Or App 248, 250-51, remanded for reconsideration, 304 Or 354 (1987); Kevin J. Geyer, 39 Van Natta 391, 394-95 (1987). We conclude, therefore, that the employer did not act unreasonably in denying claimant's aggravation claim and that no penalty and attorney fee is warranted.

4. Premature Closure

The Referee concluded that claimant became medically stationary on or before January 20, 1987 and remained such until the Determination Order issued on August 25, 1987. She indicated that claimant's condition had not worsened to the point of medical instability in May 1985, but had simply waxed and waned. In support of this conclusion, she noted that the evidence gave no indication that claimant had experienced an increase in permanent partial disability as a result of the September 1986 aggravation. Claimant contends that he never became medically stationary between the time that his condition worsened in September 1986 and the date of the hearing.

After reviewing the evidence in this case, we conclude that claimant became medically stationary on January 20, 1987. This conclusion is supported by the Orthopaedic Consultant's report in November 1986, a report by Dr. Eisenbart, a consulting chiropractor, and the report by the Independent Chiropractic Consultants in February 1987. We also conclude, however, that claimant's condition worsened to the point of medical instability in May 1987 and remained such until after the Determination Order issued in August 1987. This conclusion is supported by Dr. Waldman's reports and testimony and by claimant's testimony. We conclude, therefore, that claimant's claim was prematurely closed and set aside the Determination Order.

5. Entitlement to Additional Temporary Disability Compensation

In view of our conclusion that claimant's claim was prematurely closed, we do not address the question of his entitlement to additional temporary disability compensation. That issue currently is a claims processing matter between the employer and claimant and will be redetermined by the Evaluation Section when the claim is again submitted for closure.

6. Attorney Fee Out of Increased Temporary Disability Compensation

Claimant's attorney is entitled to a fee consisting of 25 percent of the additional temporary disability compensation accruing to claimant as a result of this order, not to exceed $3,800. ORS 656.386(2); OAR 438-15-055(1).

7. Offset

Because claimant's claim remains open, we decline to address the issue of the employer's entitlement to an offset of overpaid temporary disability compensation. The employer should direct its request for an offset to the Evaluation Section when claimant's claim is again submitted for closure.

ORDER

The Referee's order dated April 11, 1988 is affirmed in part and reversed in part. Those portions of the Referee's order that excluded Exhibit 25, awarded claimant's attorney a fee of $300 for inducing the employer to rescind its aggravation denial and rejecting claimant's request for a penalty and attorney for unreasonably denying his aggravation claim are affirmed. The remainder of the Referee's order is reversed. The Determination

Order dated August 25, 1987 is set aside as premature and the claim is remanded to the employer for processing according to law. Claimant's attorney is entitled to a fee out of the increased temporary disability compensation accruing to claimant as a result of this order, not to exceed $3,800. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $2,665.50.

RODGER M. HANSON, Claimant
McNutt & Thrush, Claimant's Attorneys
Foss, Whitty, et al., Defense Attorneys

WCB 87-18480
October 12, 1989
Amended Order on Review

The Board issued an Order on Review in the above captioned matter on October 5, 1989. On our own motion, we hereby withdraw our October 5, 1989, order in its entirety, and issue the instant Amended Order on Review, effective this date.

Specifically, we amend to apply new ORS 656.268, rather than former ORS 656.268. While we are well aware of the ORS 656.202(2) "safeguard" against applying new statutes retroactively, we find that new ORS 656.268 does not change the law with regard to either claimant's continued right to the payment or the amount of benefits. Accordingly, we amend solely to apply new ORS 656.268 to this case.

The insurer requests review of that portion of Referee Brown's order which found that the Hearings Division lacked jurisdiction to determine when claimant's back condition became medically stationary. Although claimant did not formally cross-request review, he argues in his brief that the insurer should be assessed a penalty and attorney fee for allegedly unreasonable claims processing.

The Board affirms the order of the Referee.

ISSUES

1. Whether the Hearings Division had jurisdiction to determine whether claimant's compensable back condition had become medically stationary, when the insurer had neither requested the Evaluation Division to close claimant's claim nor issued a Notice of Closure.

2. Whether the assessment of a penalty and attorney fee is appropriate.

FINDINGS OF FACT

Claimant compensably injured his back on June 7, 1986. Shortly thereafter, he began treating with Dr. Meece, a chiropractor. On December 2, 1987, the insurer issued a denial of chiropractic treatment in excess of the then current administrative guidelines. See 436-10-040(2)(a). Claimant appealed the denial by requesting a hearing on the following issues: (1) denial of medical services; and (2) penalties and attorney fees. The insurer cross-requested relief, contending that claimant's condition had become medically stationary on February 6, 1987.

The hearing convened on February 23, 1988. At the beginning of the hearing, claimant withdrew his request for hearing:

"[Claimant's attorney]: The issues today concern number one, a Denial by [the insurer] dated December 2, 1987. What [the insurer] denied was medical services outside of the regulations, that is, two times a month. We now, at the day of hearing, would make representation that we agree that [claimant] will treat within the administrative guidelines, and therefore, that Denial can stand." (Emphasis added).

At the time of the hearing, the medical evidence concerning claimant's medically stationary status was divided. The Orthopaedic Consultants opined that claimant was medically stationary as of February 6, 1987. Dr. Meece expressed no opinion on the subject. The Western Medical Consultants examined claimant on June 30, 1987, and opined that he would become medically stationary within 45 days. Dr. Aitchison, M.D., examined claimant in October, 1987, and opined that claimant was not medically stationary.

At the time of the hearing, claimant's claim remained open and the insurer had neither requested the Department of Insurance and Finance to issue a Determination Order, ORS 656.268(2), nor issued a Notice of Closure, ORS 656.268(3).

CONCLUSIONS OF LAW

Jurisdiction

At the hearing, claimant withdrew his appeal of the insurer's medical services denial. The insurer, however, did not withdraw its cross-request on the issue of whether claimant had become medically stationary on February 6, 1987. The Referee declined to decide the medically stationary issue on jurisdictional grounds. We agree.

ORS 656.268(2)(a) & (3)(a) & (b) provide, inter alia:

"(2)(a) * * * [W]hen the injured worker's condition resulting from a disabling injury has become medically stationary, * * * the insurer or self-insured employer shall so notify the Department of Insurance and Finance, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined.

"(3)(a) When the worker's condition has become medically stationary and the worker has returned to work, the claim may be closed by the insurer or self-insured employer, without the issuance of a determination order by the Department of Insurance and Finance.

" (b) Findings by the insurer or self-insured employer regarding the extent of the worker's disability in closure of

the claim shall be pursuant to the same standards as used by the Department of Insurance and Finance. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker and to the Department of Insurance and Finance." (Emphasis added).

As we interpret the statutory scheme of ORS 656.268(2) & (3), once an insurer obtains medical reports indicating that a worker's condition is medically stationary, it must initially submit the worker's claim to the Department of Insurance and Finance for claim closure or, if insurer closure is appropriate under subsection (3), issue a Notice of Closure. Only thereafter, may the authority of the Hearings Division be invoked to contest the findings contained in a Determination Order. See MacDonald v. Safeway, 87 Or App 86 (1987).

Relying on ORS 656.283(1), the insurer argues that it may request a hearing on "any question concerning a claim." As applied here, however, the insurer's reliance on ORS 656.283(1) is misplaced. The issue of whether claimant was medically stationary was not ripe at the time of the hearing. As we found above, the statutory scheme of ORS 656.268(2) & (3) required the insurer to either obtain a Determination Order or issue a notice of closure before the authority of the Hearings Division could be invoked to determine the effective date that claimant became medically stationary.

The insurer also relies on the case of Rodgers v. Weyerhaeuser, 88 Or App 458 (1987). In Rodgers, the worker requested two hearings. In the first hearing, he raised, inter alia, the issue of entitlement to additional temporary disability benefits. Apparently before his claim had been closed, the hearing convened and the Referee issued his order on February 29, 1984. In determining the temporary disability issue, the Referee found that the worker was medically stationary on a certain date. Significantly, no appeal was taken from the Referee's decision. 88 Or App at 460.

Later, while the worker's claim remained open, the insurer, in Rodgers, terminated the worker's temporary disability benefits. The worker then requested a second hearing raising, inter alia, the issue of the termination of his temporary disability benefits. The Referee ultimately found that because claimant had not proven a "worsening" of his condition since the prior Referee's order in February, 1984, he was not entitled to additional temporary disability benefits. The Board affirmed the Referee. Although the Rodgers court found that the Referee and the Board had erred in requiring the worker to show a "worsening" it, nonetheless, affirmed the Board.

In sum, Rodgers neither approved nor disapproved the prior Referee's finding in February, 1984, that the worker was medically stationary. In fact, no appeal was taken on that issue and it was not before the Rodgers court. Accordingly, we find that Rodgers has little application to the instant case.

Penalty and Attorney Fee

At the hearing, claimant withdrew his appeal.

Thereafter, the only issue before the Referee was the insurer's cross-request pertaining to whether claimant was medically stationary on February 6, 1987. It is well settled that a party cannot raise an issue for the first time on Board review. Vickie L. Olivares, 39 Van Natta 698 (1987).

ORDER

The Referee's order, dated March 3, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $768.

HUN J. KIM, Claimant
Welch, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-09851
October 12, 1989
Order on Remand

This matter is on remand from the Court of Appeals for reconsideration under the standards in Armstrong v. Asten-Hill Co., 90 Or App 200, 205 (1988). Kim v. Mt. Hood Community College, 95 Or App 406 (1989). On remand, we issue the following order.

Claimant requests review of Referee Mulder's order that upheld the insurer's denial of his claim for an injury to his left shoulder, collarbone and ribs. We reverse.

ISSUE

Whether claimant's injury arose out of and in the course of his employment.

FINDINGS OF FACT

Claimant sustained injuries while contributing his labor to a charitable foundation. The insurer denied the compensability of those injuries.

Claimant is employed as a controls technician in the employer's maintenance department. He is responsible primarily for maintaining heating, ventilating and air-conditioning controls. In the Spring of 1986 claimant's supervisor met with the maintenance staff during work hours to solicit contributions toward "packages" of labor to be auctioned for the benefit of the Mt. Hood Community College Foundation. The contributions were not required. The foundation is a non-profit corporation whose sole purpose is to raise money for the benefit of the employer and its students. All proceeds from the foundation's auction go to benefit the employer and its students. The foundation's board of directors includes the employer's president, dean of administration and two board members.

Nine of the ten department employees, including claimant, agreed to donate their labor to two "home maintenance packages." They understood that they would not be paid for their labor. Each "package," which sold for approximately $300, offered the services of volunteers to do various tasks around the successful bidder's home. Claimant and the other volunteers met at the employer's premises on Saturday, May 17, 1986, which was not a work day. Both "packages" were to be performed off the employer's premises, at private residences. Using the employer's equipment, they completed the first job by noon. Claimant ate lunch on the employer's premises. During the second job, claimant

fell off the roof while cleaning the gutters. He sustained a concussion and fractured left clavicle.

FINDING OF ULTIMATE FACT

Claimant's injury arose out of and in the course of his employment and, therefore, is work related.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the relationship between claimant's injury and his employment was not sufficient to find that the injury is compensable. We disagree.

A compensable injury is an "accidental injury ... arising out of and in the course of employment." Former ORS 656.005(8)(a) (now ORS 656.005(7)(a)). The ultimate inquiry under the statute is whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Rogers v. SAIF, 289 Or 633, 642 (1980). In determining whether an injury is work related, we look to the relationship between the activity resulting in injury and claimant's employment. The courts have identified the following persuasive factors: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employe at the time of hiring or later; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employe was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employe was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, Rankin, 74 Or App 571, 574, rev den 300 Or 249 (1985); Jordan v. Western Electric, 1 Or App 441, 443-44 (1970). See also Richmond v. SAIF, 58 Or App 354, 357, rev den 293 Or 634 (1982).

The employer here benefited directly and substantially from the contribution of labor to the auction. Auction of the maintenance "packages" raised approximately $600 for the sole benefit of the employer and its students. The fact that the money was raised by a separate entity from the employer, i.e., the foundation, is not significant where, as here, that entity is a non-profit corporation whose sole beneficiary is the employer. Indeed, the employer and the foundation share some of the same management personnel, further evidencing their close institutional ties.

We further find that this volunteer activity was contemplated by the employer and claimant and that it was acquiesced in by the employer. Indeed, the employer solicited vounteers for the activity on its premises during working hours, and some of the college's equipment was used in the activity with the employer's approval. Additionally, we find that, although claimant was injured while contributing his labor off the employer's premises, some of the activity occurred on the premises. The employe-volunteers met at the college's maintenance shop in the morning, and some of the crew, including claimant, later ate lunch at the shop. We also find that claimant was not on a personal mission at the time of his injury. He injured himself while donating his labor for the benefit of his employer.

The remaining factors weigh against compensability. Claimant was not paid for the activity. The activity resulting in claimant's injury was not an ordinary risk of his employment as a controls technician, nor did the injury occur on the employer's premises. However, those factors are not decisive. After weighing all the factors, we find that claimant's injury is work related. See Mellis, supra; Jordan, supra. See also Richmond, supra. We conclude, therefore, that her injury is compensable.

ORDER

The Referee's order dated June 2, 1987, is reversed. The insurer's denial of May 30, 1986, is set aside and claimant's injury claim is remanded to the insurer for preocessing according to law. For services before every prior forum, claimant's attorney is awarded a reasonable assessed fee of $4,000, to be paid by the insurer. The Board approves a client-paid fee not to exceed $150.

ROGER L. SHEPHARD, Claimant
Schwabe, et al., Attorneys
Charles Paulson, Attorney
Cooney, et al., Attorneys
Dixon, et al., Attorneys
Pozzi, Wilson, et al., Attorneys

WCB TP-89010
October 12, 1989
Third Party Order

The paying agency has petitioned the Board to resolve a dispute concerning a purported third party settlement. See ORS 656.587; 656.593. The paying agency contends that the settlement between claimant and the Professional Liability Fund (the malpractice insurer for claimant's attorney in the third party lawsuit) is void for want of prior approval by the paying agency. The Professional Liability Fund ("the Fund"), on behalf of claimant, argues that the Board lacks jurisdiction to address the issue. Alternatively, the Fund asserts that the paying agency's lien does not extend to the settlement proceeds.

We conclude that we may properly exercise jurisdiction over this matter and that the paying agency's lien attaches to the proceeds of the settlement in question. Moreover, the settlement agreement is void because it was not made with the approval of the paying agency.

FINDINGS OF FACT

On November 10, 1984, while employed as a construction laborer, claimant injured his right knee. The claim was accepted by the paying agency.

On February 13, 1986, the paying agency informed claimant that his accident and resulting compensable injuries might have been caused by the fault of a third party contractor at the construction site. The paying agency also informed claimant of his right to elect to seek recovery against the third party or parties who caused the accident or to assign his cause of action to the paying agency. The notification informed claimant that if he elected to pursue a third party claim for damages, the paying agency had a lien against any recovery and that any settlement must be approved by the paying agency.

On May 8, 1986, claimant's then-attorney notified the paying agency that claimant elected to seek recovery against the

third party or parties responsible for his November 10, 1984 accident. Claimant subsequently commenced a third party action against several third parties by the filing of a complaint in circuit court. Claimant's attorney notified the paying agency of the commencement of the third party action.

On October 6, 1987, claimant's attorney filed an amended complaint which attempted to add an additional defendant to the suit. On March 11, 1988, an order was entered in circuit court which dismissed claimant's complaint against this additional defendant on statute of limitations grounds.

The paying agency was subsequently notified that claimant's attorney was deceased and that claimant was now represented by new counsel. Claimant's new counsel informed the paying agency that he had advised claimant that claimant had a malpractice claim against the estate of claimant's former attorney. Claimant's former attorney was insured for malpractice through the Fund.

On October 21, 1988, with the approval of the paying agency, claimant settled his third party claim against one of the third party defendants. The settlement agreement, together with confirming correspondence between counsel, acknowledged the existence of a dispute between the paying agency and claimant concerning whether the paying agency could enforce its third party lien rights against any settlement of the legal malpractice claim.

On March 16, 1989, the Fund notified the paying agency that claimant's legal malpractice claim had been settled for the sum of $34,665. Under the terms of that agreement, $23,110 was released to claimant. The remaining $11,555 was held in trust by the Fund pending the outcome of any claims of lien asserted by the paying agency.

The paying agency subsequently petitioned the Board for relief pursuant to ORS 656.576 to 656.595.

FINDINGS OF ULTIMATE FACT

Claimant's malpractice claim against his former attorney was ancillary to his third party action.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. If the worker elects to pursue a third party action, and if the worker settles the third party claim, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(1); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any settlement by the worker is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the Board. ORS 656.587.

The paying agency argues that claimant's settlement with

the Fund is void because it was not made pursuant to either written approval from the agency or Board order. In response, the Fund contends that the paying agency's statutory lien does not extend to a recovery against an attorney, or the attorney's insurer, for damages resulting from alleged malpractice arising out of the third party action.

A similar factual situation involving settlement of a legal malpractice claim was presented to us recently in Charlene Toole, 41 Van Natta 1392 (1989). In Toole, we discussed the Court of Appeals' decision in Shipley v. SAIF, 79 Or App 149, rev den 301 Or 338 (1986). Claimant in Shipley recovered a judgment for the negligence of a third party defendant. However, the insurer for the third party defendant refused to pay the judgment. Claimant then filed an action against the insurer on the policy. A jury found in favor of claimant and awarded him the amount of the original judgment plus interest.

SAIF, the paying agency on the underlying claim, asserted its statutory lien on the recovery. Claimant objected to SAIF's lien. Claimant argued that the lien can only arise out of an action for the "negligence or wrong of a third person" and not out of an action by the beneficiary of an insurance contract. We rejected claimant's argument and held that SAIF had a valid lien. Claimant sought judicial review.

On review, the court affirmed. The court reasoned as follows (79 Or App at 152):

> "Plaintiff elected to seek recovery against the third party, and he successfully obtained an award of damages for the negligently inflicted injury. Only because the third party's insurer denied coverage did plaintiff have to initiate an action to recover the amount of the judgment. That action was ancillary to the action against the insured, because, without the judgment against the insured, no cause of action against the insurer could have existed. Plaintiff's ultimate recovery of damages arose out of the negligent conduct of the third party, and the proceeds are properly subject to a lien by SAIF."

Based upon our interpretation of Shipley, we concluded in Toole that a paying agency's lien extends to a malpractice settlement entered into between a claimant and the Fund.

Here, the Fund presents the same arguments, subject to further exposition, as were presented in Toole. We are not persuaded by those arguments. We continue to hold that a paying agency's lien extends to the malpractice settlement entered into between a claimant and the Fund. We adopt our discussion in Toole in this regard.

Anticipating this possibility, claimant and the Fund placed a portion of the settlement funds into a trust account pending resolution of this matter. However, the paying agency is entitled to approve or disapprove of the settlement agreement.

ORS 656.587. Because the paying agency was not allowed an opportunity to object to the settlement agreement, the agreement is void.

IT IS SO ORDERED.

ROBERT E. CARPER, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0435M
October 13, 1989
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his 1977 back injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's current back condition and related surgery, and it recommends that his claim be reopened for the payment of temporary disability benefits. However, SAIF would have such payments commence upon termination of temporary disability benefits claimant is currently receiving for a separate 1984 knee injury.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find a worsening of claimant's compensable back condition requiring inpatient or outpatient surgery, or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Following our review of this record, we are persuaded that claimant's compensable back injury has worsened requiring surgery. Accordingly, his claim is reopened for temporary disability compensation to commence July 6, 1989, the date he was hospitalized for back surgery. When appropriate, the 1977 injury claim should be closed by SAIF pursuant to OAR 438-12-055. SAIF shall continue paying temporary disability compensation until claimant is medically stationary and the claim is closed or claimant returns to regular work at the regular wage. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

Claimant is apparently receiving temporary disability compensation for a separate 1984 knee injury. He is not entitled to receive double the statutory sum for the same period of time loss because he has two separate disabling injuries. 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). SAIF may petition the Compliance Division for a pro rata distribution of payments between the 1977 and 1984 claims. See OAR 436-60-020(2).

IT IS SO ORDERED.

ARTHUR R. MORRIS, Claimant
Douglas L. Minson, Claimant's Attorney

Own Motion 89-0063M
October 13, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his March 14, 1977, industrial injury. Claimant's aggravation rights have expired. The insurer accepts responsibility for the proposed surgery, but opposes reopening of claimant's claim for temporary disability benefits on the ground that he has withdrawn from the work force.

Under ORS 656.278(1)(a), we may exercise our "own motion" authority and reopen a claim when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

It is undisputed that claimant's compensable injury has worsened requiring further surgery. Rather, the dispositive issue is whether claimant has withdrawn from the work force. If so, claimant is not a "worker" within the meaning of the Workers' Compensation Law and, hence, may not receive temporary disability benefits. See Cutright v. Weyerhaeuser Co., 299 Or 290, 300 (1985).

Based on our review of this record, we find that claimant has not worked since at least 1983. Furthermore, claimant's motivation to seek work, or lack thereof, has been at issue in prior Board proceedings relating to his 1977 injury claim. The insurer cites the determinations in those prior proceedings as evidence of claimant's withdrawal from the work force. For example, by Opinion and Order dated January 17, 1984, a prior Referee declined to award claimant permanent total disability benefits due to his lack of motivation to return to work. Additionally, by Own Motion Order dated September 15, 1986, the Board denied claimant's request for permanent total disability benefits due to a similar lack of motivation. However, those previous findings regarding claimant's motivation to find work do not conclusively establish that he has effectively withdrawn from the work force. Instead, we look to claimant's current efforts to seek work.

This record is devoid of any evidence that claimant has looked for work since 1986. However, Dr. Nash, the consulting neurosurgeon, reported in November, 1988, that claimant has been "totally unemployable" since 1986. There is no contrary medical evidence. Based on that uncontroverted assessment of claimant's vocational capacity, we find that reasonable efforts to find work would have been futile due to the continuing conditions relating to claimant's compensable injury. Moreover, claimant represents through counsel that he wants to return to work and that he is submitting to the proposed surgery in hopes that it will restore his vocational capacity and return him to work. Based on those representations, we find that claimant is willing to work. We find, therefore, that claimant was in the work force at the time his condition worsened. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). He is entitled to temporary disability benefits.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he is hospitalized for the proposed surgery and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $200, as a reasonable attorney fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

NOTICE TO ALL PARTIES: A party may ask the Board to reconsider this order. A request for reconsideration must be

received by the Board within 30 days of the mailing date of this order. See OAR 438-12-065(2). If the request is accompanied by evidence not previously submitted to the Board, we will only consider that evidence if: (a) the record, without the additional evidence has been improperly, incompletely or otherwise insufficiently developed; and (b) the additional evidence was not previously obtainable with due diligence by the party requesting reconsideration. See OAR 438-12-065(3).

In addition, if this order decreases or terminates a former award of compensation, claimant may appeal this order to the Court of Appeals. The insurer may appeal this order if it increases a former award. Any appeal must be filed with the Court of Appeals, Supreme Court Building, Salem, Oregon 97310 within 30 days of the date of this order. See OAR 438-12-065(1).

RICHARD I. BOWE, Claimant	WCB 87-11257
Richard F. Lancefield, Claimant's Attorney	October 16, 1989
Nelson, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Lipton's order which dismissed his hearing request concerning the insurer's denial of claimant's claim for pleuritis and pneumonitis on the basis that the request for hearing was untimely filed. With his appellant's brief, claimant has submitted affidavits to the effect that the denial was never received and that his response to the insurer's motion for dismissal was not considered by the Referee. He requests that the matter be remanded to the Referee. We deny the request for remand and affirm the Referee's order.

ISSUE

Whether this case should be remanded for a determination of the timeliness of claimant's hearing request.

FINDINGS OF FACT

Claimant filed a claim for right lung pleuritis and pneumonitis in March 1986. The insurer denied claimant's claim by a letter dated June 2, 1986. The denial letter was sent June 2, 1986, by certified mail, to claimant's last known address. The postal service attempted to deliver the letter on June 3, 1986, and again on June 10, 1986. It was returned to the insurer as unclaimed on June 18, 1986. The denial letter was then sent by regular mail on June 19, 1986 and was not returned to the insurer. Claimant requested a hearing on the insurer's denial on July 17, 1987. Claimant contended that his claim was compensable and asserted that he had never received notice of the denial.

On November 9, 1987, the insurer moved for dismissal of the hearing request on the basis of timeliness. The motion was accompanied by an affidavit stating when the denial letters were mailed to claimant at his last known address. By an order dated November 27, 1987, the Referee dismissed claimant's request for hearing, noting that claimant had failed to respond to the insurer's motion.

FINDINGS OF ULTIMATE FACT

The insurer's denial letter was mailed to claimant's last known address on June 2, 1986 by certified mail, and mailed to claimant's last known address on June 18, 1986, by regular mail.

CONCLUSIONS OF LAW

Claimant contends that this matter should be remanded to the Referee primarily on the basis that he never received the insurer's denial, and, secondarily, on the basis that the Referee did not consider his affadavit asserting that he had not received the insurer's denial. We disagree.

ORS 656.319(1)(a) requires claimant to request a hearing within 60 days of notification. Good cause must be established by claimant if a hearing request is filed after the 60th day, but not later than 180 days after the notification of denial. ORS 656.319(1)(b). The date of mailing, not receipt, starts the running of the 60 day period. Wright v. Bekins Moving & Storage Co., 97 Or App 45 (1989); Cowart v. SAIF, 86 Or App 748, 750 (1987); Madewell v. Salvation Army, 49 Or App 713, 716 (1980).

In the instant case, the record, consisting of an affidavit from the insurer's claims examiner establishes that its denial was mailed to claimant at his last known address on June 2, 1986 by certified mail. Claimant does not contend that that letter was misdirected. The record further establishes that a second denial letter was mailed to the same address, through regular mail on June 18, 1986. Claimant did not request a hearing until approximately 13 months after the June 2, 1986 denial.

Assuming, without deciding, that claimant did not receive the denial letter, we conclude that the hearing request is untimely, as the time period in which to request a hearing begins running at the date of mailing. Wright, supra. Accordingly, the hearing request, received more than 180 days after the date of the denial, was untimely regardless of whether or not claimant actually received the insurer's denial. In other words, the "good cause" exception of ORS 656.319(1)(b) does not apply. Under these circumstances, the Referee's dismissal of claimant's hearing request was correct.

ORDER

The Referee's order, dated November 27, 1987, is affirmed.

DAVID L. PRESCOTT, Claimant
Martin McKeown, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 86-06412 & 85-11533
October 16, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Brown's order which affirmed a Determination Order that did not award unscheduled permanent partial disability for a low back condition. On review, the issue is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings" numbered 1 through 5 with the following supplementation.

As a result of his compensable low back injury, claimant is permanently restricted to occasionally lifting and carrying 21 to 50 pounds and frequently lifting and carrying 11 to 20 pounds. Further, claimant cannot repetitively bend, twist, lift or sit for prolonged periods of time.

As a result of his compensable injury, claimant has sustained permanent impairment in the minimal range.

FINDINGS OF ULTIMATE FACT

As a result of his compensable low back injury, claimant has sustained a 10 percent loss of earning capacity.

CONCLUSIONS OF LAW

The Referee found that claimant had permanent limitations, but concluded that they were attributable to an anatomical defect and not the compensable injury. We disagree and modify.

Prior to the 1984 compensable injury, x-rays showed no sign of a degenerative condition. Following the 1984 injury, degenerative spondylarthrosis was detected. Dr. Matteri reported that this degenerative change and the resultant strain was the cause of claimant's symptomatology following the 1984 injury. In 1986, Dr. Adams noted that claimant did have x-ray changes in his lower back that were suggestive of degenerative changes. Dr. Bernstein reported that claimant's low back condition developed from a prior 1981 compensable injury and was aggravated by the 1984 compensable injury, but stated that neither injury was a "well-defined event."

Both Drs. Matteri and Adams report that claimant's 1984 injury is causally related to his current condition. Although Dr. Bernstein refers to a prior compensable injury, x-rays did not document the degenerative condition until after the 1984 compensable injury. Thus, to the extent that Dr. Bernstein's opinion can be interpreted to relate all of claimant's symptoms to the 1981 injury, we find the opinion unpersuasive. Somers v. SAIF, 77 Or App 259 (1986).

In conclusion, the weight of the medical evidence suggests that the current symptoms attributable to claimant's degenerative condition are related to his compensable 1984 injury. Thus, to the extent that the 1984 compensable injury rendered the degenerative condition permanently symptomatic, those symptoms are considered in rating permanent disability. See Barrett v. D & H Drywall, 300 Or 325, 328 (1985).

We note parenthetically that the employer argues that claimant has returned to work and is receiving a wage commensurate with his pre-injury wage. Such a factor, however, is not necessarily determinative in regard to an evaluation of a permanent loss of earning capacity. See Jacobs v. Louisiana-Pacific, 59 Or App 1 (1982).

In rating the extent of claimant's permanent disability, we consider his permanent impairment attributable to the compensable injury, which includes the permanent symptoms related to his preexisting degenerative condition, and all the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). After considering the aforementioned guidelines, we conclude that an award of 10 percent unscheduled permanent disability provides appropriate compensation for the loss of earning capacity claimant has sustained as a result of his 1984 compensable low back injury.

ORDER

The Referee's order dated December 4, 1987, is modified. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for his 1984 low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,000. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $322.50.

TERRY R. DIARMIT, Claimant	WCB 86-16382
Quintin B. Estell, Claimant's Attorney	October 18, 1989
Gail Gage (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Emerson's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim for a low back injury; and (2) affirmed a Determination Order that declined to award unscheduled permanent partial disability. On review, the issues are aggravation and extent of permanent disability. We affirm.

The Board adopts the Referee's "Findings of Fact" and makes the following additional findings.

Claimant's 1986 injury with the Oregon National Guard (ONG) independently contributed to a worsening of his compensable low back condition.

Claimant's low back condition was medically stationary immediately prior to the ONG injury. At that time, he suffered no permanent loss of earning capacity due to the 1983 compensable low back injury with SAIF.

The Board adopts the Referee's "Conclusions and Reasons", except that we note that contrary to the Referee's statement at the top of page 3, an Oregon insurer is not automatically relieved of responsibility for a worsening of its compensable injury when another jurisdiction accepts a claim for a new injury. Rather, the Oregon insurer is relieved of responsibility only if the injury accepted in the other jurisdicition independently contributed to a worsening of the condition. Miville v. SAIF, 76 Or App 603, (1985); Harry W. Clark, 38 Van Natta 808 (1986). As we find that the 1986 ONG injury did independently contribute to a worsening of claimant's condition, the Miville doctrine is applicable and the Referee's ultimate decision is correct.

In regard to the issue of extent of permanent disability, the Referee was correct in rating claimant's permanent disability

based on claimant's condition prior to the injury at ONG. See Refugio Guzman, 39 Van Natta 808 (1987).

ORDER

The Referee's order dated December 7, 1987 is affirmed.

KELLY B. WORDEN, Claimant — WCB 86-17624
Emmons, Kyle, et al., Claimant's Attorneys — October 18, 1989
Cliff, Snarskis, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Daron's order which: (1) upheld the insurer's partial denial of claimant's medical services claim for payment of an anti-depressant prescription; (2) upheld the insurer's partial denial of claimant's medical services claim for an athletic club membership; and (3) affirmed a Determination Order which did not award unscheduled permanent disability for a low back injury. On review, the issues are medical services, membership in an athletic club, and extent of permanent disability. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury in November 1985 when he slipped and fell on the ice. He was originally seen by Dr. Neal, who provided conservative care. He was placed on physical therapy and was diagnosed as having a thoracic strain. He was referred to Health Resources System, who diagnosed a mid-thoracic sprain and strain, but did not accept him as a patient.

In March 1986, claimant was seen by Dr. Stanley, who diagnosed a back strain, probable muscle ligament in origin, and recommended physical therapy and medication. In April 1986, claimant was seen by Dr. Lewis, orthopedist. Dr. Lewis' assessment was "rule-out herniated L4-5 disc with left L5 radiculopathy versus facette injury." He recommended a CAT scan be performed.

The CAT scan was negative and Dr. Lewis recommended physiotherapy and a work hardening program. In July 1986 Dr. Lewis released claimant to light duty work. In October 1986, Dr. Lewis reported that claimant should have no permanent impairment as a result of his industrial injury, but felt that claimant would likely need psychological treatment as there were little objective findings to support the subjective complaints.

The Orthopaedic Consultants performed an independent medical examination in October 1986. The Consultants diagnosed contusion of the left hip, by history, and psychological factors interfering with recovery. On October 14, 1986, Dr. Lewis prescribed a membership, for therapeutic purposes, at an athletic club for use of the jacuzzi. In November 1986, claimant was seen by Dr. Klein for a psychiatric evaluation. Dr. Klein diagnosed a preexisting personality disorder and reported that claimant would not benefit from any psychiatric treatment. A December 1, 1986 Determination Order closed claimant's claim with no award of permanent disability. A second Determination Order issued on December 16, 1986, which affirmed the prior Determination Order.

In February 1987, claimant was examined by Dr. Keller, neurologist, on referral from Dr. Lewis. Dr. Keller diagnosed chronic myofascial pain and prescribed an anti-depressant for treatment of the chronic pain. In April 1987, the insurer denied claimant's claim for the membership at the athletic club. In May 1987, the insurer denied claimant's claim for the anti-depressant prescription.

Claimant is 30 years old and has attained his GED. He has previously worked as a forklift driver, carpenter, delivery truck driver, cashier/clerk, landscape laborer, dishwasher, stable cleaner, choker setter, and gas station attendant.

CONCLUSIONS OF LAW

Compensability of Anti-Depressant Prescription

The Referee found that the anti-depressants were prescribed for treatment of claimant's preexisting personality disorder and not claimant's compensable back injury. He concluded that the prescription was therefore not compensable. We agree.

Claimant is entitled to all reasonable and necessary medical treatment required as a result of his compensable injury. ORS 656.245(1). In the present case, the anti-depressant was prescribed by Dr. Keller, a neurologist, on a trial basis in an effort to avoid narcotic painkillers. There were no objective neurological findings at that time. Dr. Keller, does not relate the prescription of the anti-depressants to the compensable injury. Further, Dr. Lewis, claimant's treating physician, noted that claimant had marked non-organic factors relating to his pain and opined that claimant did not have any objective impairment. Finally, Dr. Klein noted factors of secondary gain, including access to narcotics, and recommended that treatment be considered only if objective findings supported such treatment. Under these circumstances, we conclude that claimant has failed to establish that the prescription for anti-depressants is reasonable and necessary as a result of his compensable back injury.

Compensability of Athletic Club Membership

The Referee concluded that an athletic club membership, even if used solely to obtain jacuzzi therapy, was not a reasonable medical service necessary for claimant's recovery from his compensable injury. We agree with the Referee, although on a different basis.

Former OAR 436-10-040(7) provides inter alia that "trips to spas, rest areas or retreats . . . are not reimbursable unless special medical circumstances are shown to exist." Here, claimant's treating physician, Dr. Lewis, opined that the nature of claimant's injury did not require jacuzzi treatment and he felt that warm showers, hot baths, hot packs and massage would be just as effective. The Orthopaedic Consultants opined that jacuzzi treatment offered no advantages in comparison with warm showers and warm packs. Under these circumstances, we conclude that no special medical circumstances existed that required claimant to have jacuzzi treatment. See Deborah S. O'Shea-Mathews, 40 Van Natta 1834, 1837 (1988).

Furthermore, we have previously held that membership in an athletic club is subject to former OAR 436-10-050(2), which requires the attending physician to maintain direct control or supervision over treatment provided by non-licensed providers. See Stephen P. Culver, 39 Van Natta 653 (1987); Sandy J. Devereaux, 37 Van Natta 156 (1985). The record does not establish that Dr. Lewis maintained any type of supervision or control over the jacuzzi treatment provided at the athletic club. Accordingly, claimant's membership in the athletic club is not in compliance with former OAR 436-10-050(2) and is also not compensable on these grounds.

Extent of Permanent Disability

We adopt the Referee's conclusions and reasoning in regard to the extent of claimant's permanent disability with the following supplementation.

In rating the extent of claimant's disability we consider his permanent physical impairment and all relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

In determining that claimant has sustained no permanent disability as a result of his compensable injury, we primarily relied on the opinion of Dr. Lewis, claimant's treating physician, who opined that claimant had no permanent impairment as a result of the compensable injury and concurred with the report of the Orthopaedic Consultants which reached the same conclusion. We note that Dr. Lewis did place restrictions on claimant in a subsequent report. However, he related those limitations to non-organic factors not associated with the compensable injury. We also note that, although Dr. Keller did not feel claimant could return to his previous job, she noted that organic causes of claimant's pain had all been negative, whereas evaluations for psychological interference had been positive.

Accordingly, we agree with the Referee's conclusion that claimant has not proven that he sustained any permanent disability as a result of his compensable injury.

ORDER

The Referee's order dated November 6, 1987 is affirmed.

MICHAEL BRUNER, Claimant
Welch, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

Own Motion 88-0065M
October 19, 1989
Own Motion Order Denying Reconsideration

The insurer requested abatement and reconsideration of the Board's August 23, 1989, Own Motion Order that set aside as premature the insurer's November 9, 1988, Notice of Closure. We abated and withdrew that order on September 7, 1989, to allow claimant additional time in which to respond to the insurer's motion. Claimant has not submitted a response. We now consider the insurer's motion for reconsideration.

We set aside the insurer's claim closure for lack of persuasive evidence to support a finding that claimant was medically stationary regarding his right knee condition. The insurer now submits additional evidence to support its closure, including letters and a medical report that were not previously submitted to the Board. The insurer also submits an affidavit by its claims examiner, which states that supporting documents were not previously provided to the Board because the Board's former Own Motion Specialist verbally represented that only those documents upon which the insurer specifically relied to close the claim should be submitted and because subsequent reports from previous treating physicians were not available at that time.

New evidence submitted with a request for reconsideration will be considered only if: (1) the record, without the additional evidence, has been improperly, incompletely or otherwise insufficiently developed; and (2) the additional evidence was unobtainable with due diligence by the moving party prior to its submission to the Board. OAR 438-12-065(3). Here, we find that the additional evidence was obtainable with due diligence prior to their submission. The additional evidence consists of letters and a medical report which are all dated in early November, 1988. After claimant appealed the insurer's claim closure, we advised the insurer by letter dated January 11, 1989, that it had 15 days in which to provide the Board and claimant copies of all materials considered by it in closing the claim. See OAR 438-12-060(2). Consequently, the insurer had at least until January 26, 1989, to obtain the documents at issue. In fact, the insurer had nine months to obtain the documents, because the Board did not review the merits of its closure until August, 1989.

Assuming the truth of the affidavits, it would not effect our finding that the additional evidence was previously obtainable with due diligence. Reliance on verbal representations by Board staff does not excuse parties from complying with the clear dictates of our rules. The rules specifically required the insurer to submit to the Board copies of all materials considered by the insurer in closing the claim. See OAR 438-12-060(2). Because the insurer failed to do so, we decline to consider the additional evidence and deny its request for reconsideration.

IT IS SO ORDERED.

ROBERT J. BUCKLEY, Claimant
Michael J. Peterson, Claimant's Attorney
Stafford J. Hazelett, Defense Attorney

WCB 86-09974
October 19, 1989
Order on Review (Remanding)

Reviewed by Board Members Myers and Gerner.

Claimant, pro se, requests review of Referee Zucker's order which: (1) found that claimant had withdrawn his hearing request; and (2) dismissed his request for hearing. On review, the issue is the propriety of the Referee's dismissal. We remand.

FINDINGS OF FACT

In April 1987, claimant timely filed a Request for Hearing. On August 27, 1987, the Hearings Division issued a Notice of Hearing, which set a hearing for November 2, 1987. On November 12, 1987, the Referee entered an Opinion and Order

dismissing claimant's request for hearing. The Referee stated that claimant's counsel had told her that claimant did not intend to pursue the remedies available through the hearing process and would not appear at the scheduled hearing.

Claimant requested Board review, stating that, "I do not wish to lose my right to appeal."

FINDINGS OF ULTIMATE FACT

The record has been incompletely and insufficiently developed.

CONCLUSIONS OF LAW

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 Referee noted that she had been advised by claimant's counsel that claimant did not wish to proceed with the hearing. The record, however, is devoid of any motions, correspondence or exhibits concerning the dismissal of claimant's request for hearing. Furthermore, because the case was dismissed without a hearing, no transcript exists. Accordingly, we find nothing in the record to support the assertion that claimant did not wish to pursue his claim. Under such circumstances, we find that the record before us has been improperly, incompletely, and insufficiently developed.

We, therefore, remand this matter to the Presiding Referee with instructions to assign this matter to a Referee to conduct further proceedings to determine whether the dismissal is justified. If the Referee finds that dismissal is justified, a final order shall issue setting forth the Referee's reasoning. Should the Referee find that claimant's hearing request should not be dismissed, this matter shall proceed to hearing on the merits of the issues raised in claimant's hearing request and upon closure of the hearing record, the Referee's order shall issue.

ORDER

The Referee's order dated November 12, 1987 is vacated and this matter is remanded to the Presiding Referee for further proceedings consistent with this order.

GLADYS DISCANT, Claimant
Malagon, et al., Claimant's Attorneys

Own Motion 88-0501M
October 19, 1989
Own Motion Order on Reconsideration

Claimant requests reconsideration of our September 10, 1988, Own Motion Determination, as corrected on September 16, 1988, that closed her claim with no additional award of compensation. We rescind our original order.

The insurer voluntarily reopened claimant's claim sometime in 1988, following the expiration of her aggravation rights. Therefore, the processing of this claim is governed by the Board's current own motion rules. See OAR 438-12-018. The current rules require the insurer to close the claim, without issuance of a Board order, when medical reports indicate that claimant's condition has become medically stationary. OAR 438-12-055. Consequently, this

claim should not have been closed by Board order. Accordingly, our September 10, 1988, order, as corrected on September 16, 1988, is abated and withdrawn. Claimant's claim is remanded to the insurer for further processing to closure. Following that closure, claimant may address its concerns to the Board by request for review of the closure.

IT IS SO ORDERED.

GLENDA J. HERRING, Claimant
Brian R. Whitehead, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 89-0426M
October 19, 1989
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her September 1, 1978, industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's condition; however, it opposes reopening of her claim for payment of temporary total disability benefits, contending that claimant has removed herself from the work force.

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

Nevertheless, to receive temporary total disability benefits for a worsening of her compensable injury, claimant must be in the work force at the time of the worsening. Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). Here, claimant concedes that she has not worked since 1984. Therefore, claimant is deemed to have withdrawn from the work force, unless she establishes that she is willing to work and that either: (1) she is making reasonable efforts to obtain employment; or (2) reasonable efforts to obtain employment would be futile because of her compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Here, we are persuaded that claimant had withdrawn from the work force at the time of her worsening. Claimant contends that she has not been looking for work during the past year due to recent surgeries on her paralyzed right vocal cord, which resulted from her compensable injury. The surgeries consisted of a teflon injection of the vocal cord in August, 1988, and removal of excess teflon in December, 1988, and again in April, 1989. Claimant alleges that she still is unable to talk. She further complains of a "bad neck and arms," apparently referring to the continuing effects of her original compensable injury. However, though claimant maintains that she is willing to work, the record is devoid of any medical evidence supporting claimant's contention that she has been physically unable to do so because of the compensable injury and resulting treatment. Absent such evidence, we do not find either that claimant has made reasonable efforts to find work or that those efforts would be futile because of her compensable injury. Accordingly, we conclude that claimant has withdrawn from the work force and, therefore, deny her request for own motion reopening.

Entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

CHARLES L. KRONER, Claimant
Merrill Schneider, Claimant's Attorney
Schwenn, et al., Defense Attorneys

WCB 87-07998
October 19, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Knudsen's order that set aside its denial of chiropractic treatment for claimant's low back injury. Claimant cross-requests review of that portion of the Referee's order that declined to assess a penalty and accompanying attorney fee for an alleged unreasonable denial. Claimant also seeks an increased attorney fee award for services rendered at hearing. We award an increased attorney fee; otherwise, we affirm.

ISSUES

1. Denial of further chiropractic care.

2. Penalties and attorney fees for alleged unreasonable denial.

3. Amount of attorney fees awarded at hearing.

FINDINGS OF FACT

Claimant, employed as a building maintenance worker, injured his low back on February 18, 1986, while shoveling snow on the employer's premises. Claimant began treating with Dr. Pettigrew, chiropractor, that same day. Dr. Pettigrew diagnosed acute lumbosacral sprain/strain with attendant myofascitis. Dr. Pettigrew provided manipulation, ultrasound, and "TENS" muscle stimulation approximately three times per week. Claimant lost no time from work.

Claimant was evaluated at the insurer's request by Dr. Thompson, orthopedic surgeon, on June 3, 1986. Dr. Thompson noted evidence of L5-S1 radiculopathy; he recommended a CT scan to establish whether claimant had a bulging disc or a disc herniation at L5-S1.

Dr. Pettigrew suggested that claimant take time off work to allow for recovery from his injury; however, claimant did not wish to miss work for fear of losing his job.

Dr. Pettigrew had claimant undergo a CT scan on December 23, 1986, which disclosed a possible central disc bulge at L4-5.

In March 1987, claimant left work due to increased pain in his leg.

On April 8, 1987, claimant was evaluated by Dr. Sirounian, orthopedic surgeon, on referral from Dr. Pettigrew. Dr. Sirounian diagnosed radiculitis of the left leg, probably secondary to a bulging disc at the L4-5 level. He

recommended continued conservative care, a trial of anti-inflamatory and muscle-relaxing medication, and lumbar traction. If there was no improvement, he would recommend a myelogram to rule out a herniated disc.

On April 24, 1987, claimant was evaluated by the Orthopaedic Consultants, at the request of the insurer.

On May 14, 1987, the insurer issued its denial letter which stated, in part:

> "Inasmuch as you have been receiving chiropractic care two to three times a week for several months, with no reported symptomatic relief, and we have received medical evidence to the effect that further chiropractic care is neither necessary nor reasonable under the circumstances, we are hereby denying coverage for further chiropractic care. We will not be covering chiropractic care after the date of this letter. This denial does not affect your rights to seek treatment with another doctor of your choice, should you desire to pursue recovery from your condition."

Dr. Pettigrew referred claimant to Dr. Brett, orthopedic surgeon. Dr. Brett examined claimant on July 2, 1987. On July 15, Dr. Brett performed a lumbar myelogram which disclosed an L4-5 disc protrusion.

Claimant continued to treat with Dr. Pettigrew through July 28, 1987.

On August 26, 1987, claimant underwent a lumbar diskectomy at L4-5.

FINDINGS OF ULTIMATE FACT

The insurer's May 14, 1987 denial was addressed to no service rendered. It was entirely prospective in nature.

CONCLUSIONS OF LAW AND OPINION

Denial of Chiropractic Treatment

The insurer's denial purports to address all post-May 14, 1987 chiropractic treatment. The denial can be read only as a denial of future medical benefits. Yet, an injured worker is entitled to all reasonable and necessary medical services for a compensable injury. ORS 656.245(1). The nature of treatment which is reasonable depends upon the worker's condition at the time the treatment is rendered; what will be reasonable in the future cannot be foreseen. Thus, a denial of care in the future is void. Thomas A. Beasley, 37 Van Natta 1514 (1985). The insurer's prospective denial must be set aside as improper. Robert M. Bryant, 41 Van Natta 324 (1989). Therefore, we need not address the merits of the denial.

Penalty and Attorney Fees

Claimant contends that, through its denial, the insurer has attempted to deny access to claimant's choice of treatment modality -- chiropractic. That is precisely what the insurer has done. However, there is nothing per se unreasonable about the attempt. But see Reynaga v. Northwest Farm Bureau, 300 Or 255, 262 (1985) (insurer may not deny an entire category of otherwise reasonable out-of-state medical services). The denial here was apparently precipitated by a report from the Orthopaedic Consultants to the effect that "[t]he utility of chiropractic treatment would appear to be negligible and should be discontinued." In light of this report, the insurer's denial was not unreasonable.

Amount of Attorney Fee

The Referee awarded claimant's attorney an assessed fee of $600 for his services at hearing. Claimant's attorney was entitled to an assessed fee both for his services in overcoming the insurer's denial and in establishing claimant's entitlement to a penalty for the insurer's untimely denial of benefits. ORS 656.386(1), 656.382(1), 656.262(10). Claimant requests an increase in the fee award.

Considering the factors set forth in OAR 438-15-010(6), we find that an assessed fee of $1200 is a reasonable attorney fee for services rendered at hearing concerning the chiropractic denial and the penalty for untimely denial issues. Accordingly, we modify the Referee's attorney fee award.

ORDER

The Referee's order dated November 27, 1987 is affirmed in part and modified in part. In lieu of the Referee's attorney fee award, claimant's attorney is awarded a reasonable fee of $1,200, to be paid by the insurer. The remainder of the Referee's order is affirmed. For his services on Board review concerning the chiropractic denial issue, claimant's attorney is awarded an assessed fee of $500, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $504.

AVA L. SINGLETON, Claimant — WCB 87-01908
Francesconi & Associates, Claimant's Attorneys — October 19, 1989
Rankin, et al., Defense Attorneys — Order on Review (Remanding)

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Brazeau's order that dismissed her request for hearing as untimely filed. On review, claimant asks that this matter be remanded to the Referee for an evidentiary hearing. On review, the issues are timeliness and remand. We remand.

FINDINGS OF FACT

Claimant alleges that on March 26, 1986, she mailed a request for hearing contesting a December 24, 1985 Determination Order. The self-insured employer received a copy of this request and responded to it in December, 1986. It does not appear on the

record before us that the request for hearing was filed with the Hearings Division until February 5, 1987.

CONCLUSIONS OF LAW AND OPINION

Former ORS 656.319(4), the law governing this case, required that notice of a Request for Hearing from a Determination Order be mailed not less than one year from the date of the Determination Order. The Board did not receive such notice until February 5, 1987.

Former OAR 438-05-040(4) directed that if a party alleged mailing of notice and relied on proof of the date of mailing, proof of mailing had to be produced from the post office. This rule was found to be invalid, as too restrictive, in Weyerhaeuser v. Miller, 88 Or App 268 (1987). In that case, the court indicated that we should make a jurisdictional finding of fact after receiving evidence regarding the mailing of notice.

The Supreme Court reversed the Court of Appeals in Weyerhaeuser v. Miller, 306 Or 1 (1988), and found former OAR 438-05-040(4) to be valid. However, we believe the course of conduct suggested by the Court of Appeals is still valid, regardless of the source of evidence required. Therefore, we remand for an evidentiary hearing consistent with the former rule.

The employer argues that claimant has had ample opportunity to present evidence of mailing. We disagree. The Referee dismissed the case without convening a hearing. We find that the record has been insufficiently and incompletely developed. ORS 656.295(5). Therefore, we remand for an evidentiary hearing on whether claimant mailed her notice of hearing to the Board on March 26, 1986.

On remand, the Referee may proceed in any manner that will achieve substantial justice. See ORS 656.283(7). Therefore, in the interests of substantial justice to all parties, should the Referee find that a bifurcation of the jurisdictional and substantive issues is appropriate, then the Referee should proceed in that manner. Furthermore, if the Referee concludes that the hearing request is untimely, the Referee is not required to proceed to the substantive issues on an alternative basis. See Anton V. Mortensen, 40 Van Natta 1177, 1702 (1988).

ORDER

The Referee's order dated November 20, 1987, is vacated. This matter is remanded to Referee Brazeau for further proceedings consistent with this order. A client-paid fee, not to exceed $252, is approved.

SALVADOR B. VALLE, Claimant	WCB 87-07343
Michael B. Dye, Claimant's Attorney	October 19, 1989
G. Howard Cliff, Defense Attorney	Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Daron's order which upheld the insurer's denial of claimant's medical services claim for a right foot injury. On review, the issue is compensability of medical services. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury to his right foot in December 1978. The injury was to the top of claimant's right foot, above the arch, and was diagnosed as a contusion by Dr. Kadwell, osteopath. Dr. Kadwell released claimant from work and temporary disability compensation was paid from December 12, 1978 through January 1, 1979. The claim was closed by a March 1979 Determination Order that did not award any permanent disability.

In June 1986, claimant slipped while picking strawberries, but did not fall. In July 1986, claimant sought treatment for right ankle and foot pain. Claimant had not sought treatment for right foot pain since 1979. In December 1986, Dr. Ellison, claimant's current treating physician, requested authorization to perform tarsal tunnel release surgery. In April 1987, the insurer issued a partial denial indicating that claimant's current right foot condition was not causally related to the compensable 1978 injury.

CONCLUSIONS OF LAW

The Referee found that claimant had not carried his burden of proving that his current right foot condition and need for medical treatment was causally related to the 1978 compensable injury. We agree.

To establish compensability of his current right foot condition, claimant must show, by a preponderance of the evidence, that the 1978 compensable injury remains a material contributing cause to his current disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). The issue of whether claimant's current right foot condition is causally related to the 1978 compensable 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 Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Ellison, claimant's current treating physician, opined that claimant's 1978 compensable injury was the basis for his current symptoms and need for treatment. Dr. Ellison had a history of claimant's lower leg being pinned against a bailer, whereas the history given at the time of the injury indicates that claimant was struck on the dorsum of the right foot. Further, Dr. Ellison was not aware of the June 1986 slipping incident. We conclude therefore that Dr. Ellison's opinion was not based on a complete and accurate history and is therefore not persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

We are likewise not persuaded by Dr. Kadwell's opinion. Although he had treated claimant following the initial injury, his concurrence with Dr. Ellison is based mainly on a lack of alternative explanations. Further, Dr. Kadwell was not aware of the June 1986 slipping incident.

Claimant sustained an injury to the top of his right foot in 1978. He did not seek any medical treatment following the incident for approximately seven years. When he sought treatment

in 1986, he had symptoms in his right ankle and various parts of the right foot other than the dorsum. Given the amount of time between the original injury and treatment in 1986, as well as the lack of persuasive medical evidence, we conclude that claimant has failed to establish that his 1978 compensable injury is a material contributing factor to his current right foot condition. This conclusion is supported by the opinion of Dr. Struckman, who was unable to find a significant cause to claimant's current symptoms and found it difficult to believe that the 1978 injury was contributing to claimant's problems given the lengthy time period.

ORDER

The Referee's order, dated December 2, 1987, is affirmed.

CURTIS H. BEST, Claimant
Malagon, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0401M
October 20, 1989
Own Motion Order on Reconsideration

Claimant requests abatement and reconsideration of our June 2, 1988, Own Motion Determination that closed his claim with an additional award of temporary total disability. He contends that closure of his claim should await the outcome of his request for hearing on the compensability of proposed pain center treatment.

We reopened claimant's claim by Own Motion Order on September 23, 1987, for a worsening of his compensable right elbow injury resulting in surgery in July, 1987. When his elbow pain persisted, physical therapy and medication were prescribed. Sometime thereafter, claimant began seeing a psychologist for pain therapy and, in February, 1988, he was hospitalized for treatment of addiction to pain medication. On March 11, 1988, the SAIF Corporation denied claimant's claim for the drug addiction treatment. Claimant requested a hearing on the denial. By Stipulation and Order of November 8, 1988, SAIF accepted the drug addiction claim and claimant's hearing request was dismissed with prejudice.

Following our review of this record, we do not find any indication that claimant has undergone "pain center" treatment, although he has received treatment for his pain from Dr. Rothman since his condition worsened in July, 1987. Moreover, SAIF's March 11, 1988, partial denial only addressed claimant's drug addiction treatment, not pain center treatment. Consequently, we do not understand claimant's assertion regarding continued temporary compensation benefits while enrolled in pain center treatment. Nevertheless, given SAIF's acceptance of claimant's drug addiction resulting from medication for pain as a compensable consequence of his compensable injury, we may consider that condition in determining whether claimant is medically stationary. After reviewing the record, we find no evidence that claimant has yet achieved medically stationary status. The most recent medical evidence is a March 1, 1988, chart note by claimant's treating physician, which indicates that claimant is continuing pain therapy. There is no mention of whether further improvement in claimant's condition is expected. Hence, we do not find that claimant is medically stationary.

Accordingly, our June 2, 1988, Own Motion Determination is abated and withdrawn. SAIF's request for own motion closure is denied as premature. Claimant's claim is remanded to SAIF for further processing according to law. SAIF may renew its request for

closure when claimant's condition becomes medically stationary. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $150, as a reasonable attorney fee.

IT IS SO ORDERED.

DONALD L. BIGNELL, Claimant
Malagon, et al., Claimant's Attorneys
Meyers & Radler, Defense Attorneys
Foss, Whitty, et al., Defense Attorneys

WCB 87-19580 & 87-19579
October 20, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Lumbermen's Underwriting Alliance requests review of those portions of Referee Brown's order that: (1) set aside its denial of responsibility for claimant's left shoulder condition; and (2) assessed a carrier-paid fee for the efforts of claimant's attorney at the hearing level. Lumbermen's also argues that claimant's attorney is not entitled to a carrier-paid fee for services rendered on Board review. In his respondent's brief, claimant contends that the Board's review of this case is limited to "questions of law" pursuant to ORS 656.307(2). The issues are scope of review, responsibility and attorney fees.

The Board adopts the "Evidence" and "Findings" sections of the Referee's order as its findings of fact. The Board adopts the "Opinion" section of the Referee's order as its conclusions of law, with the following additional comments.

The Board's scope of review is limited under ORS 656.307(2) only upon appeal of the determination of an arbitrator. An arbitrator is not appointed unless the Director issues an order pursuant to ORS 656.307(1). No such order was issued in this case. The Board's scope of review, therefore, is not limited by ORS 656.307(2).

Because no .307 order has been issued in this case, claimant's entitlement to receive compensation has remained at risk throughout the proceeding. See Ronald L. Warner, 40 Van Natta 1082, 40 Van Natta 1194 (1988). Because of this, claimant's attorney is entitled to a carrier-paid fee for services rendered both at the hearing level and on Board review. Carl W. Buchanan, 41 Van Natta 366, 370-71 (1989); Dale L. Tichenor, 41 Van Natta 179 (1989).

ORDER

The Referee's order dated March 30, 1988, as supplemented and republished by the Order on Reconsideration dated April 27, 1988, is affirmed. Claimant's attorney is awarded $530 for services on Board review concerning the scope of review and responsibility issues, to be paid by Lumbermen's Underwriting Alliance. A client-paid fee, payable from Lumbermen's to its counsel, is approved, not to exceed $779. A client-paid fee, payable from Liberty Northwest to its counsel, is approved, not to exceed $984.

LEON E. COWART, Claimant
Galton, et al., Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney

WCB 84-02070
October 23, 1989
Order on Remand

Reviewed by Board Members Crider and Brittingham.

This case is before the Board on remand from the Court of Appeals. Cowart v. SAIF, 94 Or App 288 (1988). In remanding to the Board, the court reversed our prior order, dated January 15, 1988, which, inter alia, reversed the Referee's finding that claimant had established good cause to excuse his untimely request for hearing. Accordingly, we proceed to address the merits of this case.

The SAIF Corporation requests review of those portions of Referee Peterson's order that: (1) set aside its partial denial of claimant's current low back condition; and (2) set aside a Determination Order as premature. Claimant cross-requests review of those portions of the order that: (1) declined to address the issue of aggravation; (2) declined to rate the extent of his unscheduled permanent disability for his neck and low back conditions; and (3) declined to rate the extent of his alleged scheduled permanent disability for his left upper and lower extremity conditions. On review, the issues are compensability, premature claim closure, aggravation, and extent of both unscheduled and scheduled permanent disability.

We reverse in part and affirm in part the order of the Referee.

FINDINGS OF FACT

The Board adopts the Referee's findings of facts labeled as "Claimant's Work History & Prior Injuries" and makes the following additional findings.

In 1981, claimant filed an industrial injury claim form, which listed his injury as a "separated shoulder" and noted additional injury to his left shoulder and neck. The injury was accepted by a check-the-box response on the claim form. SAIF did not formally accept a low back injury.

None of the physicians had a complete and accurate medical history. Claimant did not inform any of the examining physicians of the fact that he had sustained injuries to his head, neck, arms, low back, and legs in an April, 1984, motor vehicle accident.

At the time of hearing, claimant suffered moderate impairment of the cervical spine.

CONCLUSIONS OF LAW

Compensability of Low Back

The Referee set aside SAIF's partial denial of claimant's current low back condition, on the basis that it was an impermissible "back-up" denial. We disagree.

An insurer's acceptance of a claim includes only those conditions specifically accepted in writing. Johnson v. Spectra

Physics, 303 Or 49, 55 (1987); cf. Georgia Pacific v. Piwowar, 305 Or 494 (1988). Knowledge or notice of a condition is not a substitute for a specific written acceptance. See ORS 656.262(9). Moreover, failure to respond to a claim or to one aspect of a claim is neither an acceptance nor a denial; silence is neutral. Johnson, supra., 303 Or at 55-8.

Here, SAIF accepted solely the left shoulder and neck conditions. Although the medical exhibits note low back symptoms thereafter, SAIF denied the compensability of the low back. It did so by issuing a procedurally proper partial denial. Johnson, supra, 303 Or at 57-8. Accordingly, we conclude that SAIF acted properly and did not issue an impermissible "back-up" denial.

We turn to the merits of whether the compensable June, 1981, neck and left shoulder injury is a material contributing cause of claimant's current low back condition. Although claimant's testimony is probative, the resolution of this issue turns largely on expert medical analysis. Somers v. SAIF, 77 Or App 259, 262 (1986); see Uris v. Compensation Department, 247 Or 420 (1967). Dr. Raaf, M.D., opined that the 1981 injury did not worsen claimant's preexisting low back condition. Likewise, Dr. Silver, a neurosurgeon, reported that there was no relationship between claimant's current low back condition and the 1981 injury. Dr. Kadwell, an osteopath, disagreed. Kadwell opined that claimant sustained moderate to severe permanent low back impairment, as a result of the 1981 injury.

On de novo review, we must weigh the evidence and choose the correct medical hypothesis. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 416 (1986). Kadwell is the only physician offering an opinion in support of claimant's case. Yet, he provides no explanation for his opinion or any analysis of the effect, if any, that claimant's prior low back surgeries may have had in causing his current low back condition. Conclusory medical opinions lacking in medical analysis, like Kadwell's, are not persuasive. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

In sum, we are not persuaded by Kadwell's opinion over that of Raaf and Silver. Claimant has not met his burden. His low back condition is, therefore, not compensable.

Premature Claim Closure

Finding that the Determination Order of February, 1984, had not evaluated the extent of claimant's unscheduled permanent disability for his low back condition, the Referee set aside the Determination Order as premature. We disagree.

Inasmuch as we have found above that claimant's low back condition is not compensably related to his 1981 neck and left shoulder injury, the Evaluation Division properly declined to rate the extent of his unscheduled permanent disability for the low back. In other words, given our above finding, there was nothing premature about the February, 1984, Determination Order.

Aggravation--Neck and Left Shoulder

The Referee set aside SAIF's partial denial of claimant's low back condition on the procedural grounds that it was an impermissible "back-up" and/or "preclosure" denial. See

Bauman v. SAIF, 295 Or 788 (1983); Roller v. Weyerhaeuser, 67 Or App 583 (1984). Concluding that the February, 1984, Determination Order had not considered claimant's low back condition in evaluating the extent of his unscheduled permanent disability, the Referee concluded that the Determination Order was premature. Consequently, he noted that it was unnecessary to reach the issue of aggravation. In the alternative, however, the Referee concluded that claimant had not proven a material causal connection between the 1981 injury and his alleged worsened neck condition and thus had not proven an aggravation. Since we have found above that the low back condition is not compensable on the merits, we proceed to address the aggravation issue.

In order to establish an aggravation claim, claimant must show "worsened conditions resulting from the original injury." ORS 656.273; see Perry v. SAIF, 307 Or 654 (1989). In addition, claimant must establish that as a result of such worsening he is more disabled, i.e., less able to work, either temporarily or permanently, than he was at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396, 399 (1986). "Worsened conditions" may take the form of either a worsening of the underlying condition or a symptomatic worsening. Id. If the latter, claimant must prove that his symptomatic flare-ups exceeded that which were contemplated at the time of the last arrangement of compensation. Gwynn v. SAIF, 304 Or 345, on rem 91 Or App 84 (1988).

Here, the last arrangement of compensation was the February, 1984, Determination Order, which increased claimant's unscheduled permanent disability award for his neck and left shoulder to 35 percent.

At the hearing, claimant testified on direct examination that he did not receive any injuries that required medical treatment as a result of the April, 1984, motor vehicle accident. On cross-examination, however, he testified to the contrary. After reviewing the record, we agree with the Referee's finding that claimant was not a credible witness. Pinkerton, Inc. v. Brander, 83 Or App 671, 674 (1987).

Claimant sustained multiple injuries in the motor vehicle accident of April, 1984. At the time of the accident, he was driving a truck. The accident caused him to hit the cab ceiling with his head and to bang the steering wheel with his legs. As a result, he was "pretty shaken up for a couple of weeks" and had, inter alia, neck and low back discomfort. To alleviate his neck and low back symptoms, he treated with a chiropractor from June through August, 1984.

The following month, claimant began to treat with Dr. Davies, an osteopath. Davies diagnosed a cervical strain and noted that it was "undetermined" as to whether claimant's neck condition was work related. (Ex. 73). As far as we are aware, the record contains no other medical opinion on the issue of causation. While Kadwell specifically mentioned the low back as causally related to the 1981 injury, in the same report he omitted any such similar mention of a causal relationship between the 1981 injury and claimant's neck condition. (Ex. 70). Moreover, there is no indication that claimant informed any of the examining physicians of the injuries he sustained in the April, 1984, motor vehicle accident. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (Medical opinions based on inaccurate medical history are entitled to little evidentiary weight).

Given the fact of an intervening nonindustrial injury to the same body part -- the neck -- and the absence of any medical opinion supporting a causal connection between the June, 1981, injury and the alleged worsened condition, we conclude that claimant has not met his burden. Accordingly, we agree with the Referee's alternative conclusion, as well as our earlier conclusion in our August 12, 1986, order, that claimant has not proven an aggravation.

Extent of Unscheduled and Scheduled Permanent Disability

We found in our August, 1986, order, that claimant had not proven entitlement to either an additional award of unscheduled permanent disability or an award of scheduled permanent disability. After reconsidering his permanent loss of earning capacity for his neck condition, ORS 656.214(5), as well as his alleged permanent loss of use or function of his left upper and lower extremities, ORS 656.214(2), we adhere to our earlier conclusion that claimant is not entitled to further permanent disability compensation. We adopt the Referee's conclusions at pages 17-18 of the Opinion and Order except that we note that claimant's total prior award for the neck injury was 35 percent rather than 40 percent. Although we have found that claimant is moderately impaired in the neck, it is impossible, based on this record, to determine what portion of that impairment is due to the compensable injury and whether claimant's neck impairment has permanently worsened since the January 5, 1983 Determination Order so as to entitle him to additional permanent disability. For that reason, we decline to increase additional permanent disability. Stepp v. SAIF, 304 Or 375 (1987). Bendix Home Systems v. Alonzo, 81 Or App 450 (1986).

ORDER

The Referee's order, dated June 4, 1985, is reversed in part and affirmed in part. That portion of the Referee's order that set aside SAIF's partial denial of claimant's low back condition, is reversed. SAIF's partial denial is reinstated and upheld. That portion of the Referee's order that set aside the Determination Order of February, 1984, as premature, is reversed. The Determination Order is reinstated and upheld. That portion of the Referee's order that declined to consider whether claimant had sustained an aggravation of his neck and left shoulder conditions is reversed. SAIF's aggravation denial is upheld. All remaining portions of the Referee's order are affirmed.

LLOYD L. CRIPE, Claimant	WCB 87-06674
Harper, Leo & Associates, Claimant's Attorneys	October 23, 1989
Schwabe, et al., Defense Attorneys	Order on Review

Reviewed by Board members Myers, Gerner and Cushing.

Claimant requests review of those portions of Referee Heitkemper's order that: (1) found he had not sustained an aggravation; (2) upheld the insurer's medical services denial; and (3) declined to assess a penalty or attorney fee.

The Board affirms the order of the Referee.

ISSUES

The first issue is whether claimant has proven a

worsened neck or low back condition resulting from the April, 1984, compensable left foot injury.

The second issue is whether the insurer unreasonably delayed accepting or denying claimant's aggravation claim of December, 1986 and if so whether claimant is entitled to a penalty or attorney fee.

The third issue is whether claimant's current need for medical treatment is materially related to his compensable injury of April, 1984.

The final issue is whether the insurer's medical services denial was unreasonable.

FINDINGS OF FACT

Claimant, 34 at hearing, compensably injured his left foot and low back on April 15, 1984. After returning to work for two days, he stopped working and sought medical treatment from Dr. Sewell, M.D. Sewell ordered x-rays of claimant's left foot, which revealed no bony injury or other pathology. On April 18, 1984, claimant began treating with Dr. Scheinberg, M.D. Scheinberg diagnosed a "contusion" of the lateral sesamoid area of claimant's left foot. That same day, claimant filed an industrial claim for an injury to his "left foot." The insurer promptly accepted the claim.

Scheinberg reexamined claimant on April 26, 1984. In addition to his left foot injury, claimant complained of low back pain. Scheinberg diagnosed claimant's back pain as a "musculoligamentous strain" and treated him with physical therapy.

During the latter part of May, 1984, claimant returned to his regular job (i.e., a "handyman" for a restaurant). On May 31, 1984, Scheinberg noted that claimant's "neck is feeling better." Claimant sought no further medical treatment until July, 9, 1984, when he returned to Scheinberg with complaints of increased low back pain. Scheinberg found no objective signs of pathology and felt that claimant could resume his normal work activities. Shortly thereafter, claimant returned to work and was fired.

The insurer closed claimant's claim with a Notice of Closure on July 24, 1984. Claimant performed various "odd jobs" through the remainder of 1984, but did not find permanent employment.

On January 27, 1985, claimant experienced a sudden onset of neck and bilateral shoulder pain, while eating at home. The next day, he sought treatment from Dr. Arbeene, M.D. Arbeene noted muscle spasm and tenderness in claimant's neck. In a follow-up examination of March, 1985, Arbeene felt that claimant's neck condition was much improved and that further treatment was not needed.

Claimant apparently sought no further medical treatment until he returned to Arbeene in August, 1985, with complaints of low back pain. The onset of his pain had occurred while he was working as a janitor. Arbeene diagnosed a low back strain that appeared to be resolving, and suggested that he return to normal work without restriction.

In December, 1986, claimant changed attending physicians and began treating with Dr. Morris, a chiropractor. Morris diagnosed a cervical strain and began treating with chiropractic adjustments. The insurer issued a denial of current chiropractic treatments on April 2, 1987. Morris reexamined claimant in June, 1987, and found that he was medically stationary with 25 percent permanent physical impairment.

Claimant was examined by Dr. Duncan, a chiropractor, in September, 1987, and October, 1987. Duncan found no objective evidence of neck pathology and felt that claimant was medically stationary with no permanent physical impairment.

Claimant's allegedly worsened neck condition of both January, 1985, and December, 1986, did not materially result from the April, 1984, compensable left foot injury.

Claimant's allegedly worsened low back condition of August, 1985, did not materially result from the April, 1984, compensable left foot injury.

Claimant's current neck condition is not materially related to the April, 1984, compensable left foot injury.

Dr. Morris's report of December 17, 1986 was an aggravation claim. The insurer did not accept or deny the aggravation claim within 60 days.

CONCLUSIONS OF LAW

AGGRAVATION

In aggravation cases involving symptomatic flare-ups, the trier of fact must initially determine whether future flare-ups were contemplated at the time of the worker's last arrangement of compensation. Gwynn v. SAIF, 304 Or 345, on rem 91 Or App 84, 87-8 (1988). If, however, future flare-ups were not contemplated, then the worker must prove: (1) a worsening of his condition, which makes him more disabled (i.e., less able to work); and (2) a causal connection between the worsened condition and the compensable injury. See Smith v. SAIF, 302 Or 396 (1987); Stepp v. SAIF, 78 Or App 438, 441 (1986).

Here, claimant returned to regular work in May, 1984. Later that month, Dr. Scheinberg examined claimant and found that: "No further orthopedic treatment is indicated at present." Although claimant returned to Scheinberg in July, 1984, with complaints of low back pain, Scheinberg found no objective signs of pathology and felt that claimant could resume his normal work activities. On July 24, 1984, the insurer issued a Notice of Closure, which closed claimant's claim with no award of permanent disability. See former ORS 656.268(3).

Inasmuch as there was little, if any, evidence at the time of the July, 1984, Notice of Closure indicating a likelihood of future symptomatic flare-ups, unlike the case in Gwynn, supra, we conclude that such flare-ups were not contemplated. See Gwynn, 91 Or App at 88. Consequently, we turn to the factual question of whether claimant experienced a worsening. Smith, supra; see also SAIF v. Perry, 307 Or 654 (1989).

Claimant had three alleged flare-ups after the July, 1984, Notice of Closure: the first, in January, 1985; the second, in August, 1985; and, the third, in December, 1986. In January, 1985, he experienced a sudden onset of neck pain, while at home. Prior to that time, there is very little mention of neck pain in the medical record. Claimant injured his "left foot" on April 15, 1984. (Ex. 3). Initial medical treatment focused nearly entirely on the left foot. The first indication of neck pain, is in Scheinberg's chart note of May 31, 1984. Thereafter, there is no further mention of a neck pain until July 17, 1984, when claimant's physical therapist noted such.

Morris is the only medical expert to link claimant's neck pain to the April, 1984, left foot injury. Yet, Morris' opinion was based on the inaccurate history that claimant suffered continuous neck symptoms following his injury of April, 1984. See Miller v. Granite Construction Company, 28 Or App 473, 476 (1977) (Medical opinion based on inaccurate history is unpersuasive). Unlike Morris, Duncan had an accurate history of claimant's neck pain. After examining claimant in October, 1987, Duncan opined that claimant's neck complaints were not related to the April, 1984, injury. We are persuaded by Duncan's opinion. Somers v. SAIF, 77 Or App 259, 263 (1986).

Accordingly, we conclude that claimant's flare-ups of January, 1985, and December, 1986, both of which concerned neck pain, were not causally related to his compensable injury of April, 1984.

We turn to claimant's alleged low back worsening of August 1, 1985. (Ex. 13). After experiencing the onset of low back pain while performing his janitorial duties, claimant sought treatment from Arbeene. Arbeene had recently examined claimant on two prior occasions. Arbeene diagnosed a low back strain that, in his view, was already beginning to resolve. He encouraged claimant to return to his normal work activities. Moreover, in July, 1987, claimant was examined by Dr. McKillop, an orthopedic surgeon. McKillop compared x-rays of the low back taken on April 26, 1984, and August 2, 1985. In McKillop's view, the x-rays showed no evidence of a worsened low back condition. (Ex. 16B-5).

Accordingly, we conclude that claimant has not established a worsened low back condition resulting from the April, 1984, compensable left foot injury. He, therefore, has not proven a compensable aggravation.

MEDICAL SERVICES

A worker is entitled to reasonable and necessary medical services for the disabling results of a compensable injury. James v. Kemper Insurance Co., 81 Or App 80, 84 (1986); ORS 656.245(1).

We have found above that claimant's allegedly worsened neck condition of both January, 1985, and December, 1986, was not causally related to the April, 1984, compensable left foot injury. Nothing in the record since that time persuades us otherwise. Accordingly, we conclude that claimant's current neck condition is not materially related to the April, 1984, compensable left foot injury.

PENALTIES AND ATTORNEY FEES
FOR DELAY IN ACCEPTING OR DENYING
THE AGGRAVATION CLAIM

ORS 656.273(3) states: "A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." An insurer must accept or deny a claim within 60 days, or risk the imposition of penalties and attorney fees. ORS 656.262(8) & (10).

Here, Dr. Morris completed a Change of Attending Physician form on December, 17, 1986. The form indicates that Morris felt chiropractic and physiotherapy treatments were needed. Pursuant to ORS 656.273(3), Morris' report constituted a claim for aggravation. The insurer did not issue an aggravation denial. Rather, its denial of April 2, 1987, was solely a denial of current medical services. Accordingly, we conclude that the insurer unreasonably delayed accepting or denying claimant's aggravation claim. ORS 656.262(10).

There are no amounts "then due" upon which we might base a penalty for the insurer's delay. ORS 656.262(10). Consequently, the Referee was correct in declining to assess a penalty.

The more difficult question is whether claimant is entitled to an attorney fee for the insurer's unreasonable delay in accepting or denying the aggravation claim. We conclude that claimant is not entitled to an attorney fee. Ellis v. McCall Insulation, 308 Or 74 (1989).

Before Ellis, the Court of Appeals decided Mischel v. Portland General Electric, 89 Or App 140 (1987). The relevant facts in Mischel are similar to the facts in this case. Claimant filed a claim for a heart condition and the insurer's denial was not timely. The denial was upheld. The court held that no penalty was appropriate because there were no amounts then due; however, it cited Spivey v. SAIF, 79 Or 568 (1986) and then held that an attorney fee could be awarded. It then reasoned:

> "We do not read ORS 656.262(10) to say that attorney fees can be allowed under that statute only under the circumstances described in ORS 656.382. We understand it to provide that attorney fees that may be assessed under the circumstances described in ORS 656.382 may also be assessed for an unreasonable denial. ORS 656.382 does not impose additional restrictions on when attorney fees may be assessed under ORS 656.262(10)." Mischel, supra at 143.

In essence, the Court of Appeals engrafted an additional basis for an attorney fee onto ORS 656.382.

Ellis, on the other hand, requires that there be an unreasonable resistance to the payment of compensation as required by ORS 656.382 before an attorney fee can be awarded under ORS 656.262(10). The court held:

> "In respect of attorney fees, the basis for

> an award of attorney fees, unlike the basis for an award of an 'additional amount' is not hinged to 'amounts then due.' Instead, ORS 656.262(10) provides that attorney fees are to be assessed under ORS 656.382. ORS 656.382, in turn, is keyed to unreasonably resisting the payment of compensation. Here the insurer did not unreasonably resist the payment of compensation where the 'claims' were unrelated to claimant's compensable injury and the insurer is not liable for the unpaid bills." Ellis, supra at 78.

We conclude that the holding in Ellis is directly contrary to the holding in Mischel. Mischel and Spivey allowed an attorney fee where there had been unreasonable actions by the insurer even where there was no finding of a resistance to the payment of compensation. Ellis requires that there be unreasonable resistance to the payment of compensation before an attorney fee may be assessed. Henceforth, we will apply our understanding of Ellis to attorney fee questions in penalty cases rather than the Mischel and Spivey rationale.

We note that Ellis does not hold that an attorney fee under ORS 656.262(10) may only be assessed where there are "amounts then due." Rather, it holds that an attorney fee may be assessed under ORS 656.262(10) whether or not there are "amounts then due" so long as there is "unreasonable resistance to the payment of compensation" under ORS 656.382. Therefore, it is for the trier of fact in each case to decide on the evidence in the record whether an unreasonable action constitutes an unreasonable resistance to the payment of compensation.

In this case, we have concluded that there was no compensable aggravation. Consequently, the delay in accepting or denying the aggravation claim did not delay any compensation and was, therefore, not an unreasonable resistance to the payment of compensation. No attorney fee may be assessed.

PENALTIES AND ATTORNEY FEES FOR UNREASONABLE DENIAL

Claimant alleges that the insurer's medical services denial of April 2, 1987, is unreasonable. Inasmuch as we found above that claimant's current chriropratic services are not compensable, we do not find the denial unreasonable.

ORDER

The Referee's order, dated March 2, 1988, is affirmed. The Board approves a client-paid fee, payable from the the insurer to its attorney, not to exceed $1,250.

GUADALUPE WARREN, Claimant
Bischoff & Strooband, Claimant's Attorneys
Charles L. Lisle (SAIF), Defense Attorney

WCB 86-13579
May 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Fink's order that declined to award her any permanent disability benefits. On review, the sole issue is the extent of claimant's unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

The record does not indicate what, if any, physical impairment is attributable to claimant's compensable cervical strain.

CONCLUSIONS OF LAW

We adopt the Referee's conclusions of law with the following comment.

In rating the extent of claimant's unscheduled permanent disability, we consider her loss of earning capacity and physical impairment attributable to the compensable injury, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 298 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Lay testimony, without medical input, may establish permanent disability. Garbutt v. SAIF, 297 Or 148 (1984). However, it may not be persuasive when the claim involves a complex medical question. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The present case involves a complex medical question. In order to rate claimant's permanent disability, we must first determine what physical impairment, if any, is attributable to the compensable cervical strain.

Dr. Hearns, claimant's treating chiropractor, opined that, based on a lack of neurologic deficit, reduced ranges of motion, or atrophy, claimant had no ratable impairment in the cervical area. Moreover, the Orthopaedic Consultants opined that the primary cause of claimant's cervical symptoms was diffuse systemic musculoskeletal disease, associated with diabetes mellitus. They did not believe that her complaints were due to overuse.

The medical evidence does not indicate what physical impairment, if any, is attributable to claimant's compensable cervical strain. It is claimant's burden to prove the extent of her permanent disability. See Hutcheson v. Weyerhaeuser Co., 25 Or App 851, 856 (1976). In the present case, claimant has failed to carry that burden.

ORDER

The Referee's order dated October 6, 1987 is affirmed.

RAY LITTLEFIELD, Claimant
Bischoff & Strooband, Claimant's Attorneys
Allen, Kilmer, et al., Defense Attorneys

WCB TP-89016
October 23, 1989
Third Party Partial Distribution Order

Reviewed by Board Members Crider and Brittingham

The paying agency has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute concerns the paying agency's asserted lien for claim costs allegedly attributable to claimant's third party action. We conclude that the agency has established its entitlement to a further portion of the remaining balance of settlement proceeds for previously unreimbursed temporary disability compensation. Because the claim remains in open status, we further conclude that a resolution of future permanent disability and claim expenditures would be premature.

FINDINGS OF FACT

In March 1980 claimant sustained a prior compensable low back injury. This injury eventually resulted in surgery at L4-5 and a 20 percent unscheduled permanent disability award.

In May 1984 claimant sustained another compensable low back injury. Further surgery and a fusion at L4-5 were recommended. The surgery was performed in April 1985. However, the surgery was performed at L3-4.

A December 30, 1986 Determination Order awarded 30 percent unscheduled permanent disability. Thereafter, the award was increased to 50 percent unscheduled permanent disability by a January 23, 1987 stipulated order. The stipulation further provided for the recovery of overpaid temporary disability, $2,000 of which was temporarily waived to permit claimant to proceed with his contemplated third party action.

Claimant engaged legal counsel to explore the possibility of bringing suit against the surgeon who performed the April 1985 operation. Thereafter, a third party action for malpractice was initiated against the surgeon.

In November 1987, in anticipation of a settlement offer concerning the action, the litigation coordinator for the paying agency represented to claimant's counsel that the agency's "'lien' to date would be somewhere around $40,000." The coordinator further noted that "[w]hat the final figure will be I cannot say as this claim is obviously not over."

In September 1988 claimant underwent a third low back surgery. Fusion surgery was performed at L4-5 and L5-S1. The L4-5 fusion would have been required for the compensable injury even if the 1985 surgery had not been performed. The L5-S1 fusion was necessitated by the April 1985 fusion. The total cost for the 1988 surgery was $19,909.01. Had a fusion been performed at one level, rather than two, the cost would have been $1,000 less. Claimant's claim was reopened and remains in an open status.

In January 1989, with the paying agency's approval, claimant and the third party settled the cause of action for

$94,000. Following distribution of litigation costs, attorney fees, and claimant's statutory one-third share, a balance of $40,614.82 from the settlement remained. The paying agency has received $27,467.47 of this balance, which consists of $11,619.67 in temporary disability compensation, $7,847.80 in medical benefits, and $8,000 in permanent disability compensation. The remainder of this balance, $13,147.58, is in dispute.

ULTIMATE FINDINGS OF FACT

As a result of the April 1985 surgery, the paying agency expended $1,000 in medical expenses that it would otherwise have not incurred. This expense, which represents the cost differential between a one-level and a three-level fusion, has already been reimbursed to the agency.

Also due to the April 1985 surgery, claimant suffered time loss from April 10, 1985 through December 29, 1986. Temporary disability compensation during this period totalled $15,318.27. The paying agency has previously received $11,619.67 as reimbursement from the settlement proceeds for this compensation.

The claim currently is in open status.

CONCLUSIONS OF LAW

To begin, claimant contends that the paying agency is estopped from asserting its lien in an amount in excess of that represented by its litigation coordinator in November 1987. We disagree with this assertion.

When a paying agency represents the amount of its claimed lien to a worker, knowing that the worker is in the process of negotiating a third party settlement, the agency may not claim as its "just and proper" share of the settlement any more than the originally asserted lien, even if the total amount claimed is not in excess of the lien authorized by ORS 656.593(1) and (2). Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987).

Here, the paying agency did not provide a precise figure concerning its third party lien. Moreover, its litigation coordinator expressly advised claimant's counsel that the stated figure was the agency's "'lien' to date" and that a final figure could not be provided because "this claim is obviously not over." Such conditional statements, offered more than one year before the eventual settlement of the third party action, do not cause us to conclude that the paying agency is prohibited from asserting a lien in excess of the approximate amount it had previously quoted.

We proceed to a determination of a "just and proper" distribution of the remaining balance of settlement proceeds.

A paying agency is entitled to the 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. John Galanopoulos, 34 Van Natta 615, 616 (1982). The burden of proof is upon the paying agency to establish the extent of the expenditures attributable to the malpractice. Id.

Here, the surgeon who performed claimant's 1988 surgery, Dr. Carr, opined that, considering the development of the disease process at L4-5 present in April 1985, in all likelihood, claimant would eventually have required a second fusion at L5-S1 even had surgery not been mistakenly performed at L3-4. However, because of the previous fusion at L3-4 and the needed fusion at L4-5, Carr concluded that it was necessary to also fuse at L5-S1. Dr. Carr gauged the difference in surgical charges between a one-level and three-level fusion at approximately $1,000.

We find the opinions offered by the treating surgeon to be persuasive. Therefore, subject to one exception, we find that Dr. Carr's 1988 surgery was related to the 1984 compensable injury rather than the 1985 surgery. That exception is the additional fusion at L5-S1 that was necessitated by the 1985 malpractice fusion surgery at the wrong disc space. The additional expense for such a procedure was estimated at $1,000.

We reject the paying agency's contention that the cost of the 1988 surgery should be treated primarily as a consequence of the malpractice, and only $1,000 treated as related to the compensable injury. Since the surgery would have been required in any event, the cost of doing a one-level fusion is not a result of the malpractice. Consequently, we hold that the paying agency has established its entitlement to receive $1,000 as reimbursement for additional expenses incurred as a result of the 1985 alleged malpractice. Inasmuch as that sum has already been distributed to the agency, no further amount for the costs of the 1988 surgery will be required.

Concerning the issue of temporary disability reimbursement, the parties agree that the 1985 surgery resulted in additional temporary disability between April 10, 1985 through December 29, 1986. Claimant has previously forwarded to the paying agency $11,619.67 as reimbursement for temporary disability benefits paid during the aforementioned period. Yet, the agency contends that its temporary disability expenses actually totalled $15,318.27.

In support of its contention, the paying agency submits copies of its claim expense records. These records are also attested to be true and accurate copies by means of an affidavit from the agency's claims supervisor. The records indicate that the paying agency paid $15,318.27 in temporary disability benefits between April 10, 1985 and December 29, 1986. Although claimant asserts that the paying agency should receive reimbursement of $11,619.67 for temporary disability compensation paid during this period, he does not challenge the authenticity of the expense records.

Inasmuch as claimant concurs that temporary disability payments made during the aforementioned period are related to the 1985 surgery and because the paying agency has submitted persuasive evidence establishing the amount of temporary disability benefits paid during that time, we hold that the paying agency has established its entitlement to the unpaid portion of these benefits. i.e., $3,698.60.

Finally, we turn to the permanent disability and future claim expenditure issues. Claimant has previously forwarded $8,000 to the paying agency. This sum represents one-half of the

50 percent unscheduled permanent disability awarded pursuant to the December 1986 Determination Order and January 1987 Stipulation which followed the April 1985 surgery. The sum of $8,000 was paid by claimant, apparently in an effort to distribute uncontested amounts early. The sum was not paid pursuant to any agreement with the insurer concerning the amount of the lien.

We reject the insurer's contention that claimant agreed, in negotiating the January 23, 1987 Stipulation, that the insurer would be repaid all permanent partial disability paid in this claim. The insurer's affidavits do not support its assertion that such an expansive agreement was made. Claimant's affidavits deny that any agreement was made. Such an agreement not having been memorialized contemporaneously, we are not persuaded it was made. Consequently, the insurer's entitlement to a lien against the malpractice recovery for permanent partial disability compensation shall be determined with reference to the principles stated in John Galanopoulos, supra. The insurer has offered no medical evidence that establishes that any portion of claimant's permanent disability was caused by the 1985 surgery. Therefore, the insurer has proven no lien for permanent partial disability in addition to the $8,000 that claimant has not contested.

The claim currently remains in open status pending closure after the September 1988 surgery which was necessitated, at least partially, by the April 1985 surgery. Considering these circumstances, claimant submits that a final determination concerning what, if any, portion of any additional permanent disability is attributable to the April 1985 surgery would be premature. We agree.

Because there has not been a final order determining the extent of claimant's disability arising out of the April 1985 surgery, we deem it appropriate to defer ruling on the question of the paying agency's entitlement to a lien for additional permanent disability. See, John T. Elicker, 40 Van Natta 68 (1988); Robert B. Williams, 37 Van Natta 711 (1985). We apply similar reasoning concerning the agency's assertion of its lien for future claim expenditures resulting from the April 1985 surgery.

Accordingly, from the $13,147.58 held by claimant's attorney in trust pending resolution of this dispute, claimant's attorney is directed to pay the paying agency $3,698.60 as additional reimbursement for temporary disability benefits paid as a result of the April 1985 surgery. The remaining balance of these funds, $9,448.98, shall continue to be held by claimant's attorney in trust pending a final determination concerning the extent of claimant's permanent disability.

Upon final resolution of the disability issue, the parties shall notify the Board if disputes continue to exist concerning what portion, if any, of claimant's additional permanent disability is attributable to the April 1985 surgery and whether the paying agency has established a lien for future expenditures attributable to the April 1985 surgery. Thereafter, the Board will consider the parties' respective positions regarding the aforementioned issues and proceed to resolve the disputes.

IT IS SO ORDERED.

FRANK L. PETERS, Claimant
Michael L. McDonough, Claimant's Attorney
Acker, Underwood, et al., Defense Attorneys

WCB 86-12448
October 23, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

The insurer requests review of Referee Huff's order that set aside its denial of claimant's low back injury claim. The issue on review is compensability. We reverse.

FINDINGS OF FACT

Claimant was employed loading sheets of raw glass weighing about 10 pounds each. On May 15, 1986, he felt soreness in his low back while working. He finished his shift and later that evening asked his girlfriend to massage his back. She sat on his buttocks and massaged his back. He attempted to arise while she was still sitting on him and felt excruciating pain in his low back.

The next morning, claimant continued to feel low back pain. He saw Dr. Dawson, chiropractor, who diagnosed acute moderate lumbosacral strain. Dawson assisted him in filling out a Form 801 and advised him not to mention the incident with his girlfriend.

Claimant delivered the Form 801 to the employer on May 21, 1986, and told the production supervisor that he felt something pop in his low back when he tried to get up with his girlfriend still partially on top of him.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant to be a credible witness and found his injury at home to be a direct and natural consequence of the original injury at work. We disagree.

While we generally defer to the Referee's credibility findings which are based on demeanor, the Referee has no greater advantage in determining credibility when it is based on the objective substance of claimant's testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). The insurer points out some inconsistencies in claimant's testimony. The insurer further points out that statements made by claimant on the Form 801 and the First Medical Report were contradicted by his testimony at hearing, and invites us to find claimant to be not credible. While we find claimant to be an unreliable historian, we do not believe this case turns on credibility.

Claimant has not shown that he suffered a disabling injury at work. He complained to no one and did not report an injury to his supervisor. He worked his full shift and went home. He did not seek medical treatment. He did ask his girlfriend to massage his back. When the massage was finished, he injured his back when he arose and struck his girlfriend with his low back.

The Referee found that this incident was a direct and natural consequence of the original injury at work. In support of that proposition, the Referee cites Rogers v. SAIF, 289 Or 633 (1980) and Fenton v. SAIF, 87 Or App 78 (1987). We find these

cases establish a "work relatedness" requirement for an original compensable injury. We find them of little benefit in deciding whether claimant's subsequent injury was a natural consequence of an original compensable injury.

An injury incurred as "direct and natural consequence" of a compensable injury is, itself, compensable. Fenton v. SAIF, 87 Or App 78 (1987); Wood v. SAIF, 30 Or App 1103, rev den 282 Or 189 (1978). Assuming a massage by his girlfriend was a "direct and natural consequence" of claimant's sore back, we are unable to find that it was a direct and natural consequence of a compensable injury.

The evidence establishes that claimant suffered soreness in his back while at work. This did not require medical services nor did it result in disability. See ORS 656.005 (7)(a). After an intervening incident with his girlfriend, claimant required medical services and was off work for two days. Under such circumstances, we conclude that the issue of whether claimant's low back pain on May 15, 1986, while working, is a compensable injury is a complex medical question requiring competent medical evidence. Kassahn v. Publisher's Paper Co., 76 Or App 105, 109 (1985).

There is not competent medical evidence in this record as to whether claimant's back pain at work would have required either medical services or time loss. The only medical evidence in the record is Dr. Dawson's "check the box" report relating claimant's complaints to his work activities. However, this opinion does not address the issue of whether the intervening incident either caused or contributed to the need for medical services. Further, claimant admitted that Dr. Dawson encouraged him to withhold information about this incident. Therefore, we give no weight to Dr. Dawson's report.

Without competent medical evidence to establish causation, we find claimant's testimony insufficient to establish that his disability and need for medical treatment is related to his work activities. Accordingly, we conclude that he has failed to prove compensability. See Frazier v. United Pacific Insurance Co., 91 Or App 528 (1988).

ORDER

The Referee's order dated October 26, 1987, is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, not to exceed $1,110, is approved.

JOE J. AGUILERA, Claimant	WCB 86-00262 & 85-15251
Pozzi, Wilson, et al., Claimant's Attorneys	October 24, 1989
Rankin, VavRosky, et al., Defense Attorneys	Order on Review
Raymond Smitke (SAIF), Defense Attorney	

Reviewed by Board Members Crider and Brittingham

The SAIF Corporation requests review of that portion of Referee Podnar's order that set aside its denial of claimant's asthma claim as an improper "back-up" denial. Claimant cross-requests review of those portions of the Referee's order that: (1) found on the merits that his asthma condition was not

compensable; and (2) affirmed a Determination Order that declined to award unscheduled permanent partial disability for a stress condition. We find that SAIF's denial is procedurally permissible. On the merits, we conclude that claimant's asthmatic condition is not compensable, and we affirm the Referee's order with regard to extent of permanent disability.

ISSUES

1. Whether SAIF's partial denial of claimant's asthma condition is a prohibited "back-up" denial.

2. Compensability of claimant's asthma condition.

3. Extent of permanent disability, if any, for claimant's accepted stress condition.

FINDINGS OF FACT

Claimant, 45 years at hearing, has worked for the employer as a warehouseman since 1964. Since about 1974, he has experienced recurrent respiratory problems, depression and dermatitis.

In April 1984, he filed a workers' compensation claim describing "noise level of generator, wine [sic] (dust and dirt), allergy cause rash on neck (job stress)."

SAIF processed the claim without issuing a written acceptance.

SAIF issued a Notice of Closure on June 18, 1984 awarding temporary disability only.

On July 5, 1984, claimant filed a second claim. Under the "Describe Accident Fully" section of the claim form, claimant referred to his prior claim number and stated "Same as before. Dust, Dirt, Black Soot, Machine Noise."

SAIF reopened the claim by letter dated July 19, 1984, which stated:

> "We have reviewed all information regarding the worsening of your condition and have reopened your claim."

Claimant received periodic treatment for his condition from Dr. Dordevich, allergist and immunologist, commencing in March 1984. He also was examined by Dr. Bardana, Director of the Occupational and Environmental Allergy Laboratory at the Oregon Health Sciences University, in April 1985. Dr. Bardana exposed claimant to an allergies mixture. The resultant allergy profile revealed that, of the allergins presented, claimant was most affected by house dust and house dust mite.

On December 6, 1985, SAIF issued a denial stating:

> "You filed a claim for stress reaction at work sustained on April 13, 1984 while working for [SAIF's insured]. Your claim was ultimately accepted and benefits were paid according to law. Your claim was

first closed by Notice of Closure dated June 18, 1984.

"Information in [your] file indicates that you suffer from a chronic and preexisting asthma/allergy condition....These conditions are probably aggravated by your smoking or other off-job factors. Review of information in your file does not indicate that your work exposure permanently worsened any preexisting asthma/allergy condition and SAIF Corporation is not responsible for any of your lung and/or breathing disorders.... Your claim will continue to be processed for your initial stress reaction...."

In the interim, Liberty Northwest Insurance Company replaced SAIF on the risk. In December 1985, claimant filed a claim with Liberty for "occupational asthma." Liberty subsequently denied the claim.

Claimant's aggravation claim with SAIF was closed by Determination Order issued March 24, 1986, which awarded additional temporary disability only.

Claimant's asthma symptoms generally worsened at night. His symptoms improved while on vacation for two weeks in Nevada in 1984.

Dr. Turco, psychiatrist and neurologist, advised that claimant not work in an environmentally-stressful workplace.

FINDINGS OF ULTIMATE FACT

Claimant experienced a short-term situational stress reaction at work which was accepted by SAIF. SAIF never accepted claimant's asthmatic condition.

Claimant's work exposure to dust, dirt and stress was not the major contributing cause of his asthmatic condition.

Claimant's reduced ability to work in an environmentally stressful work place has not been caused or worsened by his work exposure.

CONCLUSIONS OF LAW AND OPINION

Back-up Denial

Once a claim is accepted under ORS 656.262(6), the employer may not, after 60 days have elapsed from notice or knowledge of the claim, deny the compensability of that claim unless there is a showing of fraud, misrepresentation or other illegal activity. Bauman v. SAIF, 295 Or 788, 793-94 (1983). Citing Bauman, the Referee determined that SAIF had already accepted claimant's asthma condition and, therefore, was precluded from subsequently denying the condition.

Shortly before the Referee's order, the Supreme Court issued its decision in Johnson v. Spectra Physics, 303 Or 49 (1987). In Johnson, the Court held that the Bauman rule applies only to a claim "specifically" or "officially" accepted by the

employer or insurer. On review, SAIF argues that its December 1985 denial is permissible under the Court's rationale in Johnson.

The Court further refined the Bauman rule in Georgia Pacific v. Piwowar, 305 Or 494 (1988). In Piwowar, the Court stated that once an employer or insurer accepts compensability of a symptom, it must continue to compensate a claimant for that symptomatic condition, even when subsequent medical evidence demonstrates that the condition is attributable to a noncompensable cause or disease. Id. at 501.

Claimant argues that SAIF knew of the allegedly work-related asthmatic condition at the time it reopened claimant's claim, and, therefore, that SAIF accepted the condition. However, SAIF is only responsible for those conditions which it specifically accepts. Johnson, supra. SAIF's knowledge of additional conditions, and even payment of medical expenses for those conditions, is immaterial. ORS 656.262(9); see North Clackamas School Dist. v. White, 305 Or 48, 54-55 n 5 (1988).

In this regard, claimant's initial claim form neither contained a reference to asthma nor to breathing difficulties. Claimant's second claim merely referenced the first claim. Although SAIF did not formally accept the initial claim (see ORS 656.262(6)), SAIF did accept the aggravation claim pursuant to its July 19, 1984 letter. Pursuant to the Court's rationale in Johnson and Piwowar, we conclude that SAIF's acceptance is limited to those conditions or symptoms expressly noted on claimant's initial claim form. Because claimant's initial claim did not refer to an asthmatic condition or symptoms, SAIF is not estopped from subsequently denying the asthmatic condition.

Compensability

In the event his decision on the "backup" denial issue was reversed on review, the Referee addressed the merits of the denial. He concluded on the merits that claimant had failed to prove the requisite causal connection between his work exposures and his asthma condition. We agree.

To establish a compensable occupational disease, a worker must prove by a preponderance of the evidence that his work exposures, when compared to nonwork exposures, were the major contributing cause of his condition. Devereaux v. North Pacific Insurance Co., 74 Or App 388, 391 (1985).

Claimant contends on review that the opinion of his treating physician, Dr. Dordevich, sustains his burden of proof on this issue. Dr. Dordevich opines that claimant's work exposure to dust was the major contributing cause of his asthmatic condition. SAIF, on the other hand, relies primarily upon the opinion of Dr. Bardana, who attributes claimant's respiratory problems to claimant's cigarette use and a documented allergic reaction to house dust and house dust mite.

We find the opinion of Dr. Bardana more persuasive for several reasons. First, as noted by the Referee, Dr. Dordevich did not identify any particular allergin in claimant's workplace. Second, claimant's symptoms were worse during the night than during the work day. While the physicians disagreed as to the possibility of a latent response to work site exposures, we find Dr. Bardana's

explanation more persuasive. Morevover, several other physicians who had earlier treated claimant for respiratory problems agree with Dr. Bardana. For example, Dr. Matsuda, claimant's regular physician, "wholeheartedly" agreed with Dr. Bardana, stating that claimant's exposure to dust at the work site was not the major contributing cause of his current asthmatic condition. Instead, Dr. Matsuda opined that work exposure to dust "may have been one of many contributing factors including house dust, house dust mite, smoking and recurrent and chronic stress problems."

We conclude that claimant has failed to prove that his work exposure to dust was the major contributing cause of a worsening of his preexisting asthma condition.

Extent of Permanent Disability

The remaining issue is extent of permanent partial disability for claimant's accepted stress reaction claim. The Referee declined to award any permanent disability. Claimant argues on review that his situational stress reaction condition precludes him from working in a dirty and stressful environment, thereby limiting the employment available to him.

In order to establish disability, claimant relies upon the reports of Dr. Turco. In particular, claimant notes Dr. Turco's recommendation that claimant return to work in a hygenic atmosphere in order to avoid a recurrence of his situational stress reaction condition. However, Dr. Turco opined that claimant's psychological condition was a "relatively brief, minor reaction" to stress at the work place. Moreover, his recommendation was prompted by psychological reasons unrelated to claimant's work exposure. Dr. Turco notes in this regard multiple nonwork-related problems and concludes that claimant's psychological difficulties are unrelated to industrial factors.

We find that claimant's earning capacity may be somewhat limited in terms of work availability, but that this limitation has not been caused by his work exposure. Rather, claimant's psychiatric difficulties merely manifest themselves when claimant is exposed to a stressful environment. We conclude that claimant has suffered no permanent impairment as a result of his work exposures.

ORDER

The Referee's order dated April 14, 1987 is reversed in part and affirmed in part. The SAIF Corporation's denial dated December 18, 1985 is reinstated and upheld. The Referee's award of an assessed attorney fee payable by SAIF is also reversed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $105, payable by Liberty Northwest Insurance Company to its counsel.

GREGORY A. CORBIN, Claimant	WCB 86-008995
Velure & Yates, Claimant's Attorneys	October 24, 1989
Kate Donnelly (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Paulus' order which: (1) upheld a Determination Order which did not award scheduled permanent partial disability for loss of use or function of the right foot, stemming from a 1985 compensable

injury; (2) allowed the SAIF Corporation an offset of $1,289.79 against any future award of permanent disability; and (3) declined to consider claimant's request for vocational assistance for lack of jurisdiction. On review, the issues are extent of scheduled disability, offset, and jurisdiction.

The Board affirms and adopts the order of the Referee, with the following supplementation and modificaiton.

Before the December 27, 1985 Opinion and Order, claimant was paid interim compensation for the period May 29, 1985 to July 3, 1985 in the amount of $1,289. That compensation was paid as a result of a claim for aggravation of claimant's July 11, 1983 injury. The December 27, 1985 Opinion and Order found that claimant had not suffered an aggravation of his 1983 injury, but had suffered a new compensable injury on May 13, 1985. The new injury claim was ordered accepted.

On June 23, 1986, SAIF paid claimant temporary total disability compensation for the period May 29, 1985 to July 4, 1985 in the amount of $1,372.11.

Claimant was not entitled to a double recovery of compensation due from May 29, 1985 to July 3, 1985, for the same injury simply because it was claimed as both a new injury and an aggravation. See, Fischer v. SAIF, 76 Or App 656 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983); Candee v. SAIF, 40 Or App 567 (1979).

To the extent that SAIF compensated claimant under his new injury claim for compensation previously paid, its payment constituted an overpayment. It may offset that overpayment against future permanent disability due under claimant's new injury claim. Buddy Tillman, 41 Van Natta 239 (1989); William J. Dale, 39 Van Natta 632 (1987).

ORDER

The Referee's order dated October 2, 1987 is affirmed as modified.

JENETTA L. GANS, Claimant	WCB 88-00411
Bischoff & Strooband, Claimant's Attorneys	October 24, 1989
Williams, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Fink's order that upheld the self-insured employer's denial of her current chiropractic treatments. In addition, she requests that the Board remand this case to the Referee for admission of a certain stipulation or, alternatively, that we take administrative notice of the stipulation. On Board review, the issues are remand, administrative notice, and medical services.

The Board affirms the order of the Referee.

FINDINGS OF FACT

Remand & Administrative Notice

While this case was pending Board review, claimant

submitted a motion to remand and, alternatively, to take administrative notice of an April 23, 1985 stipulation, which awards claimant 7.5 percent unscheduled permanent disability for a compensable back injury sustained on June 6, 1984.

Medical Services

Claimant sustained two compensable back injuries, while the employer was on the risk. The first injury occurred on August 1, 1983, and the second on June 6, 1984.

Neither the August, 1983 nor the June, 1984 compensable injury is a material contributing cause to claimant's current back condition.

CONCLUSIONS OF LAW

Remand & Administrative Notice

The Board may remand a case to the Referee if it finds that the record has been incompletely, improperly or otherwise insufficiently developed. ORS 656.295(5). To warrant remand for the purpose of admitting additional evidence, it must be shown that the additional evidence was not available at the time of the hearing in the exercise of due diligence. Bernard L. Osborn, 37 Van Natta 1054 (1985).

Here, we are not persuaded that the additional evidence (i.e., the stipulation) was unavailable. Claimant has presented no case for "due diligence." We, therefore, decline to remand.

The Board may, however, take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2) (OEC 201(b)). This has been held to include orders of the Board and stipulations of the parties. Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); see Susan K. Teeters, 40 Van Natta 1115 (1988). Inasmuch as the additional evidence at issue is a stipulation of the parties, pursuant to Groshong and Susan K. Teeters, we grant claimant's request to take administrative notice of the April, 1985 stipulation.

Medical Services

After conducting our de novo review of the entire record, including the April, 1985 stipulation, which awarded claimant 7.5 percent unscheduled permanent disability for her injury of June, 1984, we adopt the Referee's conclusions on the medical services issue.

ORDER

The Referee's order, dated April 19, 1988, is affirmed. The Board approves a client-paid fee, payable from the self-insured employer to its attorney, not to exceed $867.

HYUN S. LEE, Claimant
Peter O. Hansen, Claimant's Attorney
Gretchen Wolfe (SAIF), Defense Attorney

WCB 86-06418
October 24, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee St. Martin's order that upheld the SAIF Corporation's denial of claimant's claim for her low back, neck, and shoulder conditions. The issue on review is compensability. We affirm.

FINDINGS OF FACT

Claimant, 43 years of age at hearing, was born and educated in Korea. She is a college graduate and taught music in Korea. Because of language and cultural barriers, she is unable to pursue that profession in this country. She has been employed as a janitor and cleaning person.

Claimant was injured in a motor vehicle accident in November, 1983. She injured her left shoulder, neck and low back when the car she was riding in was struck in the rear. She saw Dr. Whang once after this accident. Dr. Whang later reported that claimant had hyperflexed and extended her neck in the accident. She started work for the employer as a janitor in January, 1984. Her neck, shoulder, and low back became symptomatic because of her work. She was examined by the Western States Chiropractic College on April 24, 1984. They reported that her injuries from the car accident caused her pain after work.

In February, 1985, Dr. Long, neurologist, performed electrographic studies on claimant's wrists and noted the possibility of mild bilateral carpal tunnel syndrome. On March 6, 1985, he diagnosed myfascial pain syndrome, secondary to the motor vehicle accident, and bilateral carpal tunnel syndrome, also secondary to the auto accident.

In August, 1985, Long opined that her present work was contributing to the carpal tunnel syndrome. He felt that she could not stay with janitorial work. He suggested to claimant that she file an occupational disease claim for her wrist condition.

In October, 1985, Dr. Long reported that the November, 1983, auto accident was the cause of the myofascial pain syndrome in the neck, shoulders and low back. He noted that there was no clear relationship between the auto accident and her wrist condition.

Claimant filed a Form 801 on September 26, 1985, stating that her wrist condition was the result of work activities. An accompanying form 827 (First Medical Report) mentions her other injuries.

On October 21, 1985, Dr. Young, chiropractor, opined that claimant had permanent impairment from her car accident and that she should quit her present employment because of those injuries. He opined that as a result of the car accident, claimant had chronic cervico-thoracic strain with myofascitis through the left trapezius muscle and interscapular area, and lower lumbar strain.

On January 20, 1986, SAIF filed Form 1502, with the Evaluation Division, describing the claim as a disabling injury, and deferring acceptance or denial.

On January 17, 1986, Dr. Button recommended surgical release on claimant's left hand. Dr. Long opined on February 27, 1986, that claimant's condition was about the same as in November, 1985. He stated the myofascial pain syndrome was secondary to the motor vehicle accident, and had been aggravated by her work activities since January, 1984.

The Orthopaedic Consultants examined claimant on February 26, 1986, and could find no objective bases for claimant's symptoms. They noted moderate to severe functional overlay and interference with the examination. They opined that it was conceivable that her carpal tunnel syndrome was work-related.

SAIF accepted claimant's carpal tunnel condition on April 7, 1986, and denied claimant's low back, neck and shoulder conditions as not work related.

Dr. Quan, psychiatrist, examined claimant as part of the Orthopaedic Consultant's examination. He opined that claimant was depressed because she could not find employment as a music teacher. He felt she needed to improve her language skills.

Dr. Watson, neurologist, opined on May 19, 1986, that it was difficult to determine the severity of claimant's injuries from the motor vehicle accident, but he indicated these injuries were minimal. He also noted claimant's depressed mental condition.

Dr. Lee treated claimant with acupuncture seven times beginning in March, 1986. He reported on July 15, 1986, that her myofascial pain syndrome had improved slightly after this treatment. He noted that claimant resisted surgery for her wrist condition and that acupuncture would not help that condition.

Physical therapy was attempted in June, 1986, but was not successful due to language and cultural barriers

Claimant filed a new Form 827 on August 25, 1986, based on Dr. Brem's diagnosis of diskal herniation or severe sprain of her left neck and fibrositis of the low back. That form states the cause of injury as handling too many overweight trash bags and cleaning tough dirt and grease from showers and ovens.

Dr. Brem opined on August 26, 1986, that he could not clearly state whether claimant's neck and back conditions were work related.

Dr. Lee opined on February 13, 1987, that in order to treat claimant's depression, it would be necessary to treat her myofascial pain syndrome.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the totality of the medical documentation did not meet claimant's burden of proof. He considered the claim to be one for occupational disease, not an industrial injury.

Claimant's brief urges alternative theories of industrial injury or occupational disease as the cause of her neck, shoulder, and low back conditions.

In addressing alternative theories, we use the two-pronged test for distinguishing between industrial injuries and occupational diseases described in O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975):

> "What set[s] occupational diseases apart from industrial injuries [is] both the fact that they can[not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment and the fact that they [are not] sudden in onset.'" 22 Or App at 16 (alterations in original) (quoting 1A A. Larson, The Law of Workmen's Compensation Sec. 41.31 (1973))

The first prong of the test requires a retrospective estimation of th likelihood that the medical condition claimed would result from the kind, rate and duration of activity of exposure alleged to be the cause of the condition. The second prong requires definition of the phrase "sudden in onset". See Thelma T. Smartt, 40 Van Natta 602 (1988).

Here, we conclude that the kind, rate, and duration of activity performed by claimant could reasonably be expected to result in the condition claimed. We also conclude that claimant's condition did not arise suddenly during a discrete period of time. Claimant relies on Valtinson v. SAIF, 56 Or App 184 (1982), in support of her "industrial injury" claim. However, in that case, claimant's condition arose after one day of performing duties other than his regularly assigned job. Here, the evidence shows that claimant's condition became symptomatic over a much longer period of time. We conclude that claimant's condition should be analyzed as an occupational disease.

To establish the compensability of her condition as an occupational disease, claimant must prove that her work activity was the major contributing cause of the worsening of her underlying condition. Weller v. Union Carbide, 288 Or 27, (1979). This presents a complex medical question requiring expert medical analysis. See Uris v. Compensation Department, 247 Or 420 (1965); Carol A. Fisher, 40 Van Natta 458 (1988).

Dr. Young and Dr. Long treated claimant at the time closest to her automobile accident and both clearly point to the accident as the cause of her neck, shoulder, and low back conditions. Dr. Young opined that claimant had suffered permanent impairment because of the accident.

The evidence does establish that claimant's condition became symptomatic because of her work activities. However, there is no evidence that her work activities actually worsened her condition. Instead, the reports of her treating physicians show that claimant's myofascial pain syndrome is about the same now as it has been since the automobile accident and remained the same after she left her employment. We find that claimant has not established by a preponderance of the evidence that her work activities were the major contributing cause of her low back, neck, and shoulder conditions, or their worsening.

ORDER

The Referee's order, dated April 28, 1987, is affirmed.

GARY D. MILLARD, Claimant
Cowling & Heysell, Defense Attorneys

WCB 85-13205
October 24, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Leahy's order that: (1) upheld the insurer's denials of claimant's aggravation claim for low back and right leg conditions; and (2) affirmed a Determination Order award of 20 percent (64 degrees) unscheduled permanent disability for his low back condition. The issues on review are aggravation and the extent of permanent disability. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back on October 24, 1983. In October 1984, Dr. Corson, orthopedist, performed a two-level fusion from L5 across L6 to the sacrum. An October 24, 1985 Determination Order awarded 20 percent unschedualed permanent disability. The claim was reopened in December 1985. A July 31, 1986 Determination Order reclosed the claim, awarding temporary disability from December 19, 1985 through January 31, 1986. The July 1986 Determination Order did not increase claimant's prior award of permanent disability.

Claimant's right leg collapsed for the first time on December 19, 1985. He has had a number of these episodes of right leg "buckling" since that time. The compensable injury to claimant's low back was not a material cause of these episodes of right leg collapse. Claimant's need for hospitalization was not materially caused by the compensable injury.

Claimant is 32 years of age and has a ninth grade education. His work experience has been as a musician, although, at the time of his injury, he was working as a clean-up man in a plywood mill. Thus, his work experience has been largely in light work. Due to his compensable injury, he can now do only light work.

Claimant has a mild impairment due to the compensable injury. As a result of the compensable injury, claimant has suffered a 20 percent permanent loss of earning capacity

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denials of claimant's aggravation claim and affirmed the July 31, 1986 Determination Order. We agree.

In order to establish a compensable aggravation under ORS 656.273(1), claimant must prove a worsening of his condition and a causal relationship between the worsening and a compensable injury. Stepp v. SAIF, 78 Or 438 (1986), Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, rev den 297 Or 82 (1984). To prove a worsening, claimant must show a change in his condition since the last arrangement of compensation which entitles him to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396 (1986).

In cases, such as this one, which involve complex medical questions, expert medical testimony is required to support claimant's contention that his present symptoms are compensable. See Uris v. State Compensation Department, 247 Or 420 (1967). When medical opinion in a case differs, well reasoned and explained medical opinions will be accepted over the opinions of even the treating physician, when that opinion is expressed in conclusory statements without explanation. Allie v. SAIF, 79 Or App 284 (1986).

Claimant was first seen in a consulting role, by Dr. Corson, an orthopedist, in November 1983. Dr. Campagna, a neurosurgeon who served as claimant's treating doctor until October 1986, first saw the claimant in August 1984. Dr. Dunn, a neurosurgeon who runs a pain clinic which claimant has tried unsuccessfully to enter, was designated claimant's treating doctor by a letter from claimant's attorney in October 1986. Dr. Dunn apparently examined claimant once on July 30, 1987.

Dr. Corson has examined claimant several times in connection with his complaints of right leg give way. Dr. Corson has consistently been unable to document any cause for the claimant's symptoms and has no explanation for his condition, despite the use of several modalities of treatment and testing and examinations by other consultants.

Dr. Campagna has also examined claimant a number of times since the July 1986 Determination Order. Dr. Campagna has consistently found that claimant's condition has remained stationary and unchanged. Following his most recent examination of claimant in August 1987, Dr. Campagna concluded that claimant's "low back condition is unchanged."

As previously noted, Dr. Dunn, at the time of the hearing, had examined the claimant once. Dr. Dunn concludes that:

> "I do feel that this patient is definitively unable to return to work and should be on time loss as a result of his injury in 6/87 which was a direct result of his original injury of 1983."

This opinion was not accompanied by any explanation of how this conclusion was reached or by what medical evidence Dr. Dunn connected the claimant's present condition with his compensable injury.

Based on the length of their involvement with claimant's medical testing and treatment, the supporting medical evidence used in arriving at their conclusions, and their relationship with claimant as the primary treating physician and his consultant, we find the opinions of Drs. Corson and Campagna to be persuasive. These opinions suppport the conclusion that there has been no worsening of claimant's condition since the July 1986 Determination Order Therefore, we conclude that claimant's condition resulting from his compensable October 1983 injury has not worsened since July 1986, the last award of compensation.

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning

capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in former OAR 436-30-380, et seq. We apply these rules as guidelines, not as restictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

The conclusions and findings of Drs. Corson and Campagna indicate that claimant has suffered permanent impairment in the mild range. While claimant is not able to return to the heavy work he was doing at the time of his injury, he is able to do light work. His past work experience has largely involved light category work.

After reviewing the relevant factors and considering the medical and lay evidence, we agree with the Referee that an award of 20 percent unscheduled permanent disability is appropriate compensation for claimant's permanent loss of earning capacity.

ORDER

The Referee's order, dated October 26, 1987, is affirmed. A client paid fee, payable from the insurer to its counsel, not to exceed $158, is approved.

ELAINE MITCHELL, Claimant	WCB 84-08768
Stanley Fields, Claimant's Attorney	October 24, 1989
Art Stevens (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Brown's order that awarded 5 percent (16 degrees) unscheduled permanent disability for contact irritant dermititis and eye irritation, whereas a Determination Order had awarded no permanent disability. The SAIF Corporation cross-requests review of that portion of the order that assessed an insurer-paid attorney fee for clarification of SAIF's denial of claimant's chronic bronchitis condition. SAIF further argues that the Referee erred in awarding claimant any permanent disability award.

ISSUES

1. Extent of unscheduled permanent partial disability for contact irritant dermatitis and eye irritation.
2. Insurer-paid attorney fee for clarification of SAIF's denial of claimant's chronic bronchitis condition.

We reverse on the extent of disability issue and affirm on the attorney fee issue.

FINDINGS OF FACT

Claimant worked as a laborer cutting seed potatoes. In March, 1984, she was exposed to Captan-5, a powdered fungicide, resulting in irritation to her skin and eyes. Dr. Otoski, the treating dermatologist, diagnosed her skin irritation as irritant contact dermititis, while Dr. Johnson, the treating opthalmologist, diagnosed keratoconjunctivitis (inflammation of

the cornea and conjunctiva) in both eyes. Otoski took claimant off work to prevent further exposure. SAIF accepted claimant's claim for both conditions.

In April, 1984, claimant saw Dr. Hale for a persistent cough. Hale diagnosed bronchitis, possibly secondary to work exposure to Captan-5. By June 18, 1984, claimant was medically stationary regarding her skin condition. The irritant contact dermititis had resolved. Acute bronchitis symptoms had also resolved, leaving claimant with chronic bronchitis.

Claimant's claim was closed by Determination Order on July 13, 1984, with no permanent disability award. Subsequently, Otoski opined that claimant's skin had become more sensitized due to Captan exposure and recommended that she not return to her previous employment, where Captan exposure and dusty conditions persist. Johnson noted some discomfort in an otherwise normal examination of claimant's eyes and restricted her from jobs involving exposure to chemical fumes or powders.

Dr. Naversen, a dermatologist, conducted an independent medical examination (IME) on SAIF's behalf. He opined that any temporary bronchitis symptoms caused by work exposure should have already resolved. He did not believe that Captan exposure caused claimant's chronic bronchitis. Dr. Montanaro, an IME allergist, attributed claimant's chronic bronchitis to her 25-year history of cigarette smoking and did not feel that Captan exposure aggravated or worsened that underlying condition. Based on Montanaro's report, SAIF issued a partial denial of claimant's "chronic bronchitis condition" on August 22, 1984.

At the time of hearing, claimant complained of occasional itching and burning about her face and neck, for which she uses a topical lotion. She also complained of occasional burning and watering of the eyes, for which she takes eye drops.

FINDING OF ULTIMATE FACT

We do not find that claimant has sustained any permanent impairment as a result of her work exposure.

We do not find that claimant's skin and eyes were permanently sensitized as a result of her chemical exposure at work.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Partial Disability

The criteria for the rating of unscheduled disability shall be the permanent loss of earning capacity due to a compensable injury. ORS 656.214(5). Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, training, skills and work experience. Id.

Both treating physicians opined that claimant has sustained permanent impairment as a result of her work exposure. Otoski felt that claimant's skin had become more sensitive due to the exposure and that any work in dusty conditions would aggravate the problem. Johnson felt that claimant's eyes were more

sensitive to irritation due to the exposure. Although we ordinarily give greater weight to the treating physicians' opinions, see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so here because their opinions were conclusory.

The IME physicians -- Naversen, Weisel and Wagner -- did not find any evidence of permanent impairment from the exposure. Weisel, an opthalmologist, found no evidence of any ocular abnormality associated with fungicidal exposure. He reported that claimant's eye complaints were minimal and could be remedied with a mild tear lubricant. Wagner, a toxicologist, opined that claimant had no permanent skin sensitization due to the work exposure. He persuasively explained that, once the skin heals from contact irritant dermititis, it returns to pre-exposure condition. The irritation would then recur only after a new exposure to the same dose that caused the previous dermititis condition. Wagner indicated that there may be permanent sensitization if there is scar tissue remaining. However, there is no evidence in this record that claimant had any amount of scar tissue after her exposure.

After reviewing the evidence, we are most persuaded by the reports of the IME physicians, particularly Wagner. Unlike the treating physicians, the IME physicians issued thorough and well-reasoned findings and opinions. See Somers v. SAIF, 77 Or App 259, 263 (1986). Based on their opinions, we do not find that claimant sustained any permanent impairment as a result of the chemical exposure at work.

The Referee also found that claimant had sustained no permanent physical impairment, or sensitization, as a result of the work exposure. He concluded, nevertheless, that claimant was permanently "disabled," because she follows her treating physicians' instructions to avoid any contact with dust and chemical fumes or powders. The Referee explained that, so long as claimant believes these instructions, she effectively precludes herself from a measurable portion of the labor market, and is therefore entitled to a permanent disability award. We disagree.

The record is devoid of persuasive evidence that claimant has sustained any psychological impairment from chemical exposure which would interfere with her ability to obtain and hold gainful employment. She has simply chosen to follow the instructions of her own treating physicians, whose opinions were justifiably rejected by the Referee in the face of more persuasive medical evidence. Under these circumstances, claimant is not entitled to any permanent disability award.

Insurer-paid Attorney Fee

This issue arose from SAIF's denial of claimant's "chronic bronchitis condition." The Referee found that claimant's initial bronchitis treatment was compensable and left no sequelae. The Referee concluded, therefore, that SAIF's denial of the chronic condition was correct. Nevertheless, the Referee awarded claimant's attorney an insurer-paid fee of $200 for "clarifying the denial." SAIF contends on review that the fee was inappropriate. We affirm the Referee's decision.

Under ORS 656.386(1), claimant's attorney may be awarded a reasonable, insurer-paid attorney fee when claimant "prevails finally"

in a hearing on an insurer's denial of compensation. We have awarded insurer-paid attorney fees for clarifying inartfully-phrased or overbroad denials. See e.g., Mickey L. Wood, 40 Van Natta 1860, 1867 (1989); Karola Smith, 38 Van Natta 76, 77-78 (1986), aff'd mem Smith v. The Hartford, 83 Or App 275 (1987).

In relevant part, SAIF's denial letter states:

> "[I]n a report by Rand Hale, M.D., ... on April 25, 1984, he examined you for a chest condition, issuing a diagnosis of 'bronchitis, possibly secondary to [work] exposure'. After careful review of medical information now in your file, it appears that your chronic bronchitis is more likely a result of your years of cigarette smoke inhalation. Therefore, without waiving other issues of compensability, SAIF Corporation in reference to your chronic bronchitis condition, hereby issues this partial denial for that condition."

While purporting to deny only the chronic bronchitis condition, the letter fails to distinguish that condition from the acute condition for which claimant initially sought treatment with Dr. Hale. Additionally, the denial letter cites to Hale's report which diagnosed only a "[b]ronchitis" condition, with no mention of any acute or chronic component. Thus, the reasonable inference is that claimant's bronchitis was denied in toto. Because claimant prevailed over the denial insofar as she proved the compensability of the acute bronchitis symptoms and initial treatment with Dr. Hale, claimant's attorney was properly awarded an insurer-paid fee. See ORS 656.386(1).

ORDER

The Referee's order dated January 27, 1987, is reversed in part and affirmed in part. The portion of the order that awarded 5 percent unscheduled disability with an attorney fee payable out of the increased compensation is reversed. The remainder of the Referee's order is affirmed.

CAROL A. NEDDEAU, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-08012
October 24, 1989
Order on Review

Reviewed by Board Members Speer and Howell

The insurer requests review of Referee Borchers' order that awarded claimant 55 percent (176 degrees) unscheduled permanent disability for a neck injury, in addition to 35 percent previously awarded by a Determination Order, for a total award of 90 percent (288 degrees) permanent unscheduled disability. The insurer also seeks, for the first time, authorization to offset an alleged overpayment of temporary total disability. On review, the issues are the extent of unscheduled permanent disability and offset. We modify the permanent disability award and deny the request for authorization to offset.

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

On review, the insurer requests authorization to offset allegedly overpaid temporary total disability. This issue was not raised at hearing and is raised for the first time on review. In Wilson v. SAIF, 48 Or App 993 (1980), the Court of Appeals stated:

> "A policy of requiring the carrier to raise a claim of offset as provided in ORS 656.268(3) will encourage the parties to litigate all of the issues at a single hearing, rather than creating new issues and a necessity for further hearings at a time after a final award of compensation has been determined." Id at 998.

Here, the offset issue was not raised before the Referee at the time of hearing, consequently the insurer has waived the issue. See Elsie Hobkirk, 40 Van Natta 778, 779 (1988). We decline to consider the issue of offset.

Turning to the merits of the case, we modify the permanent disability award.

Claimant was 42 years old at hearing. She has a high school education and work experience in shipping, computer assembly, and other physical occupations. She has few, if any, transferable skills not related to physical work activity.

Claimant has a chronic cervical strain superimposed on preexisting degenerative disc disease. She has had two diskectomies and continues to suffer disabling pain in her neck and cervical back. Claimant is restricted by her attending physician to sedentary work where she will not have to extend her arms or work above eye level. She is restricted in lifting to 10 pounds. Her treating physician has released her to some work, such as lab technician, with modifications. Based on her physician's restrictions and her underlying cervical degenerative disease, we conclude that claimant has, as a result of her work activities, suffered permanent impairment in the moderate range.

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider her physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in former OAR 436-30-380, et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

The Referee found that claimant could not compete for semi-skilled labor because of her restrictions and lack of transferable skills. Based on the testimony of Mr. McNaught, a vocational counselor who had reviewed claimant's file and performed a 90 minute interview, the Referee concluded that claimant could no longer compete for 90 percent of the jobs in the labor market which were available to her prior to the injury. She concluded that, as a result of her compensable injury, claimant suffered permanent disability beyond the amount awarded by the Determination Order. We agree, but we consider the Referee's 90 percent award to be excessive.

It appears that the Referee awarded the 90 percent unscheduled permanent disability based on Mr. McNaught's opinion that 90 percent of the labor market previously available was no longer open to claimant. McNaught testified that claimant had lost the ability to perform 90 percent of the job titles she could perform prior to her compensable injury. We consider such an opinion to be of little assistance in determining claimant's lost earning capacity, since the number of jobs within each title and wages for each title vary dramatically. Consequently, McNaught's conclusion that 90 percent of the labor market has been foreclosed from claimant does not necessarily follow.

Moreover, the approach suggested by the Referee to determine the extent of unscheduled permanent disability ignores other relevant factors included as guidelines. See former OAR 436-30-380 et seq. We have previously rejected such a mechanical approach. Merle M. Chrisman, 40 Van Natta 789, 791 (1988).

After reviewing the medical, vocational, and lay evidence, including claimant's credible testimony, and considering the guidelines described in former OAR 436-30-380 et seq, we conclude that a total award of 75 percent (240 degrees) unscheduled permanent disability appropriately compensates claimant for permanent loss of earning capacity for her compensable injury. Consequently, we modify the Referee's award.

ORDER

The Referee's order dated November 20, 1987, is modified. In lieu of the Referee's award, and in addition to the Determination Order award of 35 percent (112 degrees) unscheduled permanent disability, claimant is awarded 40 percent (128 degrees) for a total award of 75 percent (240 degrees) unscheduled permanent disability for her neck injury. Claimant's attorney fee is adjusted accordingly. A client-paid fee, not to exceed $1,394, is approved.

DON E. PORTER, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-05646
October 24, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the self-insured employer's denial of claimant's claim for a neck and back condition; (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial; and (3) admitted a medical report over claimant's objection. We reverse on the merits and award a penalty and associated attorney fee.

ISSUES

1. Admission of evidence.

2. Compensability of claimant's neck and back condition.

3. Penalties and attorney fees.

FINDINGS OF FACT

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

Dr. Duncan examined claimant on October 27, 1987. Dr. Duncan waited to complete his report of the examination until he had an opportunity to review x-rays of claimant. Dr. Duncan subsequently completed his report on November 9, 1987, the day before the scheduled hearing. The employer submitted the report at the hearing. Claimant objected to the report as being untimely submitted.

FINDINGS OF ULTIMATE FACT

Claimant's work exposures with the employer were the major cause of a cervicothoracic strain/sprain. Claimant's cervicothoracic strain/sprain required medical treatment and resulted in disability.

At the time of its denial, no reasonable grounds existed for the employer to doubt compensability of the claim.

CONCLUSIONS OF LAW AND OPINION

Admission of Dr. Duncan's Report

Claimant objected below to the admission of Dr. Duncan's report, and now argues the Referee abused her discretion in admitting the document. We disagree. Dr. Duncan's report was completed less than 7 days prior to the hearing, after the receipt of x-rays showing a degenerative condition. Claimant was provided a copy of the report within 7 days of its receipt by the insurer. We find no abuse of discretion by the Referee in admitting the document.

Compensability

The Referee treated the claim as one for occupational disease. In this regard, an occupational disease is distinguished from an injury in that a disease does not arise unexpectedly and is gradual rather than sudden in onset. James v. SAIF, 290 Or 343, 348 (1981); O'Neal v. Sisters of Providence, 22 Or App 9 (1975).

Here, there was no specific incident at work which caused claimant's cervicothoracic condition to become disabling. Instead, claimant had experienced cervicothoracic pain for a period of three years prior to the onset of more severe pain in his neck and right shoulder on November 24, 1986. Moreover, in light of the physical nature of claimant's employment duties, the condition claimed was not unlikely to follow such activities. Therefore, we agree with the Referee's characterization of the claim as one for occupational disease.

In order to prevail on an occupational disease claim, claimant must show that his work activities and exposures either caused the condition or, in the case of a preexisting condition, worsened the preexisting condition. Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). Claimant is also required to prove that the work activities and

exposures were the major contributing cause of the condition or its worsening. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985).

Here, Dr. Duncan opined that claimant suffers from degenerative joint disease of the spine. Dr. Duncan further opined that the degenerative disease was not related to claimant's work activities. The Referee accepted Dr. Duncan's opinion. Moreover, the Referee rejected the claim on the basis that claimant had failed to establish that his preexisting degenerative condition was either caused or worsened by his work activities and exposures.

However, compensability of the degenerative condition was not the issue before the Referee. Instead, the issue before the Referee was the compensability of claimant's back and neck condition at the time of his claim in November 1986. In December 1986, Dr. Coltrin diagnosed claimant's complaints as cervical thoracic sprain which he related to claimant's work and which required medical services. In turn, Dr. Duncan diagnosed a possible thoracocervical over-use-type strain resulting from claimant's work in November 1986. This is the extent of the medical evidence on this question. There is no evidence that claimant was not suffering from a compensable cervicothoracic strain at the time of his claim.

We conclude that claimant has established a compensable occupational disease claim for cervicothoracic strain/sprain. The fact that Dr. Duncan diagnosed a separate degenerative condition in October 1987 which, he opined, was responsible for claimant's continuing symptoms goes to the extent of claimant's permanent disability, if any, from the compensable strain/sprain. Dr. Duncan's diagnosis does not detract from our conclusion that claimant has established a compensable claim in the first instance.

Penalties and Attorney Fees

Claimant asserts entitlement to a penalty and related attorney fee for the employer's allegedly unreasonable denial. ORS 656.262(10). The employer argues that it entertained a legitimate doubt as to the compensability of the claim because of the gradual onset of claimant's symptoms while engaged in normal work activities. See Norgard v. Rawlinsons, 30 Or App 999 (1977).

We fail to see how the fact that claimant's symptoms were gradual in onset could reasonably result in doubt as to the compensability of the claim. To the contrary, as noted above, compensable occupational diseases are, by definition, gradual in onset. Further, as argued by claimant, the employer had no medical evidence disputing compensability of the claim at the time of the denial. See Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). We conclude, therefore, that the employer's denial was unreasonable.

ORDER

The Referee's order dated December 10, 1987 is reversed. The self-insured employer's denial is set aside and the claim is remanded for processing according to law. The employer shall pay claimant a penalty equal to 25 percent of the compensation then due claimant at the time of the insurer's

denial. Claimant's attorney is awarded a reasonable attorney fee of $500 for services regarding the penalty issue at the hearing level and on Board review, to be paid by the employer. In addition, for services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer. A client-paid fee, not to exceed $1,148, is approved.

KENNETH J. RICKERD, Claimant
Vick & Gutzler, Claimant's Attorneys
Bottini, et al., Defense Attorneys

WCB 87-11514
October 24, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of those portions of Referee M. Johnson's order that: (1) set aside its medical services denial of claimant's current chiropractic treatments; (2) set aside its partial denial of his right ankle condition; and (3) awarded an additional 5 percent (16 degrees) unscheduled permanent disability for his low back condition, beyond a Determination Order award of 15 percent (48 degrees). On review the issues are medical services, compensability, and extent of unscheduled permanent disabiliity.

The Board reverses on the medical services issue, but, otherwise, affirms the order of the Referee.

FINDINGS OF FACT

Save for "Findings of Fact" 9 through 11, the Board adopts the Referee's findings and makes the following additional findings.

Claimant has not worked since the August, 1986, compensable back injury. He concedes that Dr. Moore's continued chiropractic care does nothing more than to temporarily reduce his pain for 30 minutes to 2 hours. (Tr. 43). He continues to treat with Moore, because Moore is the only doctor who has "stuck with him." (Tr. 13 & 44).

CONCLUSIONS OF LAW

The Board adopts the Referee's "Opinion," save for that portion of the opinion under the heading: "Frequency of Chiropractic Care[.]"

Finding that the medical physicians in this case had a "built-in bias against the chiropractic philosophy and procedure," the Referee accorded "little weight" to their opinions and set aside the employer's medical services denial. We disagree. As far as we aware, alleged "bias" on the part of the medical physicians has never been an issue in this case. Furthermore, we find no basis to find that the medical physicians are biased.

We note that, although the Referee's heading states, "Frequency of Chiropractic Treatment", the "frequency" of Moore's treatment is not at issue. The employer's denial is a denial of current chiropractic services on the basis that such services are not reasonable and necessary. (Ex. 58).

A worker is entitled to reasonable and necessary medical services for the disabling results of a compensable injury. ORS 656.245(1); James v. Kemper Insurance Company, 81 Or App 80 (1986). When the medical opinions are divided, we must choose the correct medical hypothesis. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 416 (1986).

Here, claimant concedes Moore's chiropractic treatments are "not alleviating the problem[.]" (Tr. 13). They are, however, resulting in a temporary reduction of pain for approximately 30 minutes to 2 hours. (Tr. 43). Claimant continues to treat with Moore because Moore has "stuck with him." (Tr. 13 & 44).

With the exception of Moore, the unanimous consensus of the medical experts is that continued chiropractic services are not reasonable and necessary. First, Dr. Spady, an orthopedic surgeon, examined claimant in November, 1986. Spady opined that continued spinal manipulations were not "reasonable and appropriate" treatment. Second, claimant's initial treating physician, Dr. Lautenbach, M.D., concurred with Spady. Third, Drs. Phipps, M.D., examined claimant in June, 1987. According to Phipps, continued manipulative therapy was palliative and of "relatively little benefit." Fourth, Dr. Schader, M.D., who examined claimant with Phipps, opined that continued chiropractic treatment was "[not] warranted." Fifth, Dr. Buza concurred with reports of Schader and Phipps. Last, Dr. Goe, a chiropractor, also concurred with the reports of Schader and Phipps, although he felt that trigger point therapy might be helpful. Goe added that pelvic manipulation treatment would be "contra-indicated" during a course of trigger point therapy.

Apparently disagreeing with the above medical opinions, Moore reported, in July, 1987:

> "[Claimant's] prognosis is guarded at this time. Further treatments should include palliative chiropractic care on an as needed basis. I do believe that he has reached a medically stationary status with his chiropractic treatments.
>
> "Further treatment would be a referral to the Northwest Pain Center * * *."

After our de novo review, we are persuaded by the nearly unanimous medical consensus that claimant's current chiropractic treatments are not reasonable and necessary. Moore's arguably contrary view -- that claimant has reached a "medically stationary status with his chiropractic treatments" -- does not persuade us otherwise.

ORDER

The Referee's order, dated May 2, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that set aside the employer's medical services denial, is reversed. The employer's denial is reinstated and upheld. All remaining portions of the Referee's order are affirmed. For services on review concerning the right ankle and extent issues,

claimant's attorney is awarded a carrier-paid fee of $50. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $1,128.

JON A. ROGERS, Claimant
T. Steven Miller & Theron G. Miller, dba,
WEST SCIO SALVAGE, Employer
Michael B. Dye, Claimant's Attorney
Elton Lafky, Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 86-09457
October 24, 1989
Order on Review

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Foster's order that upheld the SAIF Corporation's denial, on behalf of West Scio Salvage, a noncomplying employer, of claimant's right leg injury claim. The issues on review are whether claimant was a subject worker of West Scio Salvage and compensability. We reverse.

FINDINGS OF FACT

Tom Clay, Beverly Rogers, and Michael Chenette were subject workers of T. Steven Miller and Theron G. Miller, doing business as West Scio Salvage.

On February 22, 1986, Steven Miller told claimant to come to work the next morning. Claimant was to be paid the minimum wage for working inside the salvage yard and would receive a percentage of the value of any scrap metal he brought in from outside the yard. This was essentially the same terms of employment for all the workers.

On the morning of February 23, 1986, claimant arrived for work with some scrap he brought from home. After this was unloaded, he was told to take a pickup truck to another location and bring back some batteries. Claimant and another person proceeded to pick up the batteries. On the way back to West Scio Salvage, the truck overturned, injuring claimant's leg. He received treatment at the hospital later that evening.

Claimant worked for West Scio Salvage for about 12 days. After a violent confrontation with Tom Clay, he was told not to return by Steven Miller. He and Beverly Rogers, his mother, subsequently filed a complaint with the Wage and Hour Division of the United States Department of Labor. This resulted in payment from Steven Miller to claimant and his mother of an amount equal to that amount found to be wages due to them from West Scio Salvage by the federal agency.

Steven Miller is not a credible witness.

ULTIMATE FINDINGS OF FACT

Claimant contracted to perform services for remuneration at the direction and control of Steven Miller.

As the result of an industrial accident while employed by Steven Miller, claimant injured his leg, resulting in a need for medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee found the evidence to be in such a confused state that he determined claimant had failed to prove he was a subject worker pursuant to ORS 656.005(27). That statute states in relevant part:

> "'Worker' means any person, including a minor * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *"

On review, both claimant and the noncomplying employer (employer) agree that the case turns on the credibility of the witnesses. We agree. The Referee did not make express credibility findings. We make the necessary credibility findings in this case based on the substance of the witnesses' testimony and not on their demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

The employer's operation can be simply described as a salvage yard which buys junk items containing metal, such as automobiles and refrigerators. These items are then reduced to scrap metals such as copper and aluminum for resale. Persons such as claimant, claimant's mother, Tom Clay, and Michael Chenette would sort through items such as a refrigerator and separate usable copper and aluminum parts. They also helped load and unload truckloads of scrap, and sorted through tires to find recappable tires.

Some of the work consisted of using acetelyne torches to remove parts of automobiles. Claimant was not skilled at this activity and required direction. Michael Chenette described himself as a foreman who directed the activities of persons such as claimant in the absence of Steven Miller. Tom Clay described himself similarly. Each was paid by Steven Miller.

Steven Miller testified that he had no employees. This assertion is inconsistent with the testimony of every other witness. This assertion is impossible to logically harmonize with the observation that claimant and others expected to be paid, and were paid, for showing up every day to perform strenuous activities.

Steven Miller further testified that he was selling the pickup truck involved in the accident to claimant. Specifically, he asserted that claimant was to pay him a certain amount each month and that claimant would earn money by using the truck to procure scrap and sell the scrap to Miller for a profit. Yet, the evidence shows that the truck did not belong to either Steven Miller or claimant at the time of the accident. Furthermore, Steven Miller bought the truck after the accident and resold it within two weeks.

We find Steven Miller's testimony in relevant part, and as a whole, to be contradicted by itself, as well as the testimony of other witnesses. We decline to give it any weight. Coastal Farm Supply v. Hultberg, supra.

Claimant testified that he was to report for work on February 23, 1986. His hourly wage was to be the minimum wage and

he anticipated other income on a percentage basis for recovering scrap. He was directed and controlled by Steven Miller, Tom Clay, and Michael Chenette. He was directed to transport batteries by Steven Miller.

The essence of this testimony is supported by the testimony of Tom Clay, Michael Chenette, and Beverly Rogers. Payment of wages by Steven Miller to claimant and Beverly Rogers, his mother, after an order by a federal agency, further supports this testimony. Steven Miller testified that he had never met claimant until February 22, 1986. There is nothing in the record that supports a conclusion that claimant wished to donate his time and services to Steven Miller.

The employer points out that claimant was not a reliable witness and that both he and his mother changed their testimony during the hearing. We agree that there is a great deal of inconsistency in all the testimony about the events of February 22-23, 1986. This hearing left no witness unimpeached. Claimant was shown to be an unreliable historian, and at times, an unreliable witness. However, in reviewing the evidence as a whole, claimant's testimony that he was an employee, subject to the direction and control of Steven Miller, was not impeached and in fact was supported by the testimony of each subject worker.

The principal factors showing employment are the direct right or exercise of control, the method of payment, the furnishing of equipment, and the right to terminate employment. See Woody v. Waibel, 276 Or 189 (1976); Bernards v. Wright, 93 Or App 192 (1988). Here, claimant was directed by Steven Miller to take a truck and bring back batteries. He was supervised within the salvage yard by Steven Miller and others. He was furnished with a truck and with other tools in the salvage yard. He was terminated by Steven Miller. He was paid by a personal check from Steven Miller, with assistance from a federal agency.

We conclude that the objective factors indicate that the employer here had the right to control the details of claimant's activities. Bernards v. Wright, supra. Therefore, we find that claimant was a subject worker of the employer on February 23, 1986.

We turn to the compensability issue.

Claimant testified that he suffered a puncture wound to his right leg as a result of the truck accident that required medical services. That testimony is supported by medical reports from the hospital and by the testimony of several other witnesses. We conclude that claimant has proven by a preponderance of the evidence that his right leg condition is compensable. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

ORDER

The Referee's order dated June 12, 1987, is reversed. The SAIF Corporation's denial, issued on behalf of the noncomplying employer, is set aside and the claim is remanded for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded a reasonable attorney fee of $2,400, to be paid by SAIF on behalf of the noncomplying employer.

WILLIAM B. SIMPSON, Claimant
Diane L. Gruber, Claimant's Attorney
David Jorling, Defense Attorney
Roy Miller (SAIF), Defense Attorney

WCB 88-17084 & 88-17085
October 24, 1989
Order on Review (Remanding)

Reviewed by Board Members Crider and Brittingham.

The City of Portland (Portland), a self-insured employer, requested review of those portions of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial of claimant's "new injury" claim for his current left shoulder and neck condition; and (2) dismissed claimant's hearing request concerning Portland's denial of claimant's aggravation claim for the same conditions and penalties and attorney fees for alleged unreasonable claims processing. Submitting post-hearing evidence which indicates that SAIF has accepted claimant's claim for the same conditions under the Longshoreman & Harbor Workers' Compensation Act (LHWCA), Portland seeks remand. We grant the motion.

FINDINGS OF FACT

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

In May 1986 claimant sustained a left shoulder and neck injury while working for Portland. The claim was accepted. This injury eventually resulted in a 5 percent unscheduled permanent disability award.

In July 1988 claimant began working as a welder for a marine iron works company, insured by SAIF. Claimant's left shoulder and neck symptoms increased. Thereafter, he filed an aggravation claim with Portland, a "new injury" claim with SAIF, and another claim with SAIF under LHWCA. All three claims were denied. Claimant appealed each denial to the appropriate forum.

The record currently under consideration does not establish that the compensability of claimant's claim with SAIF under the LHWCA has been finally determined. The submitted evidence, which was unobtainable with due diligence at the time of hearing, suggests that SAIF has accepted claimant's claim under the LHWCA.

CONCLUSIONS OF LAW

Concluding that claimant was a subject worker under SAIF's coverage pursuant to the LHWCA, the Referee upheld SAIF's denial of claimant's workers' compensation claim.

On the merits of claimant's aggravation claim with Portland, the Referee found that claimant's 1986 compensable injury remained a material contributing cause of claimant's current condition. However, the Referee further concluded that claimant's subsequent work activities as a welder for the marine iron works independently contributed to his condition. Inasmuch as the compensability of claimant's claim for this condition under the LHWCA had not been finally determined, the Referee dismissed the hearing request without prejudice insofar as it pertained to consideration of the aggravation claim. The Referee relied upon the reasoning expressed in Miville v. SAIF, 76 Or App 603 (1985).

Portland requested Board review of the Referee's order. Portland now submits documentation indicating that, subsequent to the hearing, SAIF accepted claimant's claim under the LHWCA. Asserting that this post-hearing evidence should be considered, Portland moves for remand. The other parties do not oppose this 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). 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. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Here, at the time of hearing, a final determination concerning the compensability of claimant's LHWCA claim with SAIF had not been achieved. Because claimant's work activities while SAIF covered the claim under LHWCA may have materially contributed to his present disability, the record was incompletely developed. Inasmuch as a final determination of the LHWCA claim was apparently made post-hearing, we hold that this submitted evidence was not obtainable with due diligence at the time of hearing. Under these circumstances, remand is appropriate. ORS 656.295(5).

Accordingly, the Referee's order dated March 9, 1989, as reconsidered March 28, 1989, is vacated. This matter is remanded to Referee Quillinan for further proceedings consistent with this order.

BRADFORD N. APPLEWHITE, Claimant	WCB 86-15553
David C. Force, Claimant's Attorney	October 25, 1989
Brian L. Pocock, Defense Attorney	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Mills' order that: (1) affirmed an award by Determination Order of 10 percent (32 degrees) unscheduled permanent partial disability for his low back; and (2) failed to assess a carrier-paid fee for his attorney's efforts in reducing an offset claimed by the self-insured employer. The issues are extent of disability and attorney fees.

The Board affirms and adopts the order of the Referee with the following comment on the attorney fee issue. Claimant contends that his attorney is entitled to a carrier-paid fee on the offset issue under ORS 656.382(1). We disagree. A fee may be assessed under ORS 656.382(1) only if the carrier "unreasonably resists the payment of compensation." The offset taken by the employer was expressly authorized by Determination Order. The fact that the Referee amended the Determination Order to award claimant additional temporary disability compensation does not render the employer's reliance on the Determination Order unreasonable. See Forney v. Western States Plywood, 297 Or 628, 632-33 (1984). No fee may be assessed, therefore, under ORS 656.382(1). No other statute authorizes a carrier-paid fee under the circumstances of this case. See id. Claimant's request for a carrier-paid fee, therefore, is denied.

ORDER

The Referee's order dated April 1, 1988, as amended by the order dated April 26, 1988, is affirmed. A client-paid fee of up to $330 is approved.

GREG CARPENTER, Claimant
Stafford J. Hazelett, Defense Attorney

WCB 87-12941
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant, pro se, requests review of those portions of Referee Knudsen's order that: (1) found that his claim had not been prematurely closed by a Determination Order; (2) declined to award additional temporary total disability compensation; and (3) declined to award additional unscheduled permanent disability for his back condition, beyond a Determination Order award of 15 percent (48 degrees). On review, the issues are premature claim closure, temporary total disability, and unscheduled permanent disability.

The Board reverses the order of the Referee.

FINDINGS OF FACT

Claimant, age 25, compensably injured his low back on October 13, 1986, while working as a punch press operator. A few days later, he sought treatment from Dr. Oehler, M.D. X-rays revealed no objective abnormalities. Oehler diagnosed a strain in the mid and low back and declined to take claimant off work. For reasons that are not ascertainable from the record, claimant's job ended on October 23, 1986.

In November, 1986, claimant began treating with Dr. Bolera, a chiropractor. Bolera took him off work and diagnosed a cervical, thoracic, and lumbar sprain/strain with associated myofascitis. Treatment was conservative. In January, 1987, Bolera referred claimant to Dr. Takacs, an osteopath. Takacs started claimant on an exercise and stretching program, which was interrupted during February or March, 1987, when he contracted Legionnaire's Disease.

Claimant was examined by Dr. Howell, an osteopath, in April, 1987. Howell found that claimant was medically stationary and in no need of further medical treatment.

In June, 1987, Dr. Takacs reported that claimant was not medically stationary. Claimant was next examined on July 9, 1987, by Dr. Hyland, a chiropractor. Hyland concurred with Dr. Bolera's diagnosis and found that claimant was not medically stationary. The following day, claimant was examined by a panel of physicians at the Western Medical Consultants, including Dr. Snodgrass, a neurologist. The Consultants found that claimant was medically stationary with minimal permanent physical impairment.

A Determination Order closed claimant's claim on August 3, 1987, awarding: (1) temporary disability benefits through July 31, 1987; and (2) 15 percent unscheduled permanent disability for the back.

Claimant's back condition was improving throughout July, 1987, and continued to do so up through the date of the hearing in December, 1987, as a result of the passage of time and Dr. Bolera's chiropractic treatments.

CONCLUSIONS OF LAW

Premature Claim Closure

To establish that his claim was prematurely closed by the Determination Order of August 3, 1987, claimant must prove, by a preponderance of the evidence, that he was not medically stationary on that date. "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

Despite finding that claimant's condition "has improved since the summer of 1987[,]" the Referee concluded that the August, 1987, Determination Order did not prematurely close claimant's claim. We agree with the Referee's finding, but disagree with her conclusion.

The Referee further found that claimant was a credible witness, save for exaggerating his physical impairment. On de novo review, we find no persuasive reason to disagree with the Referee's credibility finding. See Pinkerton, Inc. v. Brander, 83 Or App 671, 674 (1987). Accordingly, claimant credibly testified that his symptoms were improving in July, 1987. (Tr. 37).

Turning to the medical evidence, we normally assign greater weight to the treating doctor's opinion, unless there are persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Dr. Bolera began treating claimant in November, 1986. His medical reports, as well as his testimony at the hearing, show that he felt claimant's back condition was improving during July, 1987, and up through the time of hearing. He has steadfastly opined that claimant's condition remains not medically stationary. Drs. Takacs and Hyland concur. On the other hand, Drs. Howell and Snodgrass opine that claimant became medically stationary no later than July 10, 1987. We are not persuaded by their opinions. Unlike Dr. Bolera, who began treating claimant shortly after his compensable injury, Howell and Snodgrass each examined claimant on only one occasion. See Hamlin v. Roseburg Lumber, 30 Or App 615 (1977).

Considering claimant's credible testimony concerning an improvement of symptoms in July, 1987, and the collective opinions of Drs. Bolera, Takacs, and Hyland, we conclude that the preponderance of the evidence establishes that claimant's back condition was not medically stationary at the time his claim was closed by the Determination Order of August 3, 1987.

Temporary Disability

Given our above finding that claimant's claim was prematurely closed, he is entitled to additional temporary disability compensation, until his claim is properly closed pursuant to ORS 656.268(1), et seq.

Unscheduled Disability

Given our above finding that claimant's back condition was not medically stationary at the time of the hearing and that his claim was prematurely closed by the August, 1987, Determination Order, the issue of the extent of his unscheduled permanent disability is not ripe. We, therefore, decline to address that issue. Mark L. Ellingsen, 40 Van Natta 2048, 2051 (1988); Myrel M. Henning, 40 Van Natta 1585, 1587 (1988).

ORDER

The Referee's order, dated January 22, 1988, is reversed. The Determination Order is set aside as premature and the insurer is directed to pay claimant temporary disability benefits from August 1, 1987, until proper closure of his claim under ORS 656.268.

LAWRENCE W. CARTER, Claimant	WCB 87-11455
Francesconi & Associates, Claimant's Attorneys	October 25, 1989
Schwabe, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Miller's order that upheld the self-insured employer's compensability denial of his heart condition. In addition, claimant requests that the Board remand this case to the Referee for the admission of certain medical documents obtained after the close of the record. On review, the issues are remand and compensability.

We deny the motion to remand and affirm the Referee.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

After the hearing, claimant apparently obtained medical documents pertaining to physical examinations he underwent in 1972 and 1982. He seeks remand for admission of these documents.

CONCLUSIONS OF LAW

Remand

We may remand if the record has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). To warrant remand for the submission of additional documents, the moving party must show that such documents were not obtainable with due diligence prior to the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, claimant argues that "through great effort" he obtained the documents in question after the hearing. We are not persuaded, however, that had such effort been performed prior to the hearing, that the documents in question would not have been obtainable. In sum, we find that remand is not necessary.

Compensability

The Referee found that claimant had not proven the compensability of his heart condition. We agree.

At issue, here, is the "fireman's presumption" of former ORS 656.802(1)(b) & (2). To satisfy the presumption, claimant must prove: (1) he has a disability or impairment of health; (2) he was employed as a fireman of a political subdivision; (3) he has completed more than five years of employment in that capacity; (4) a disease of hypertension or cardiovascular-renal disease caused his disability or impairment; and (5) he had a physical examination subsequent to his becoming a fire fighter "which failed to reveal any evidence of such condition of impairment of health which preexisted [his] employment." Johnson v. City of Roseburg, 86 Or App 344, 347 (1987). The Referee found that claimant had not proven the last element; i.e., element "(5)."

We take no position on that finding because we conclude that even if claimant has successfully established the elements of the fireman's presumption, the employer has successfully rebutted the presumption by proving by clear and convincing evidence that the cause of claimant's heart condition was not related to his employment as a fire fighter.

The employer has presented unrebutted expert medical opinion that claimant's heart condition is not related to his employment as a fire fighter. (Ex. 15). Although we find claimant's testimony probative, the etiological complexities of this case are most persuasively addressed by expert medical analysis; not lay opinion. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). In a well reasoned report, Dr. Simkoff, M.D., opined, inter alia:

> "In summary, there is absolutely no convincing medical evidence that this patient's condition or impairment was in any way related to his job as fire fighter and given his family history and cigarette smoking, there is no doubt in my mind that he would have developed coronary artery disease regardless of his occupation."

This evidence is sufficient to establish by clear and convincing evidence that claimant's heart condition was not caused by his work as a fire fighter.

ORDER

The Referee's order, dated April 29, 1988, is affirmed. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $1,706.

GERALD C. COUZENS, Claimant
Pozzi, et al., Claimant's Attorneys
Stafford J. Hazelett, Defense Attorney

WCB 87-04645
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Huff's order that increased claimant's unscheduled permanent disability award for a low back injury from 15 percent (48 degrees), as awarded by a Determination Order, to 30 percent (96 degrees). The issue on review is extent of unscheduled permanent disability.

We affirm and adopt the order of the Referee with the additional ultimate finding of fact and following comment.

As a result of his compensable injury, claimant has suffered permanent impairment in the mild range and has sustained a permanent 30 percent loss of earning capacity.

After the briefs were filed, the insurer filed a motion to submit supplemental authority regarding the applicability of new rules adopted by the Director regarding the evaluation of unscheduled permanent disability after the amendment of ORS 656.295(5) by the 1987 Legislature. Supplemental briefs are generally not allowed. See Betty L. Juneau, 38 Van Natta 553 (1986). However, the issue raised by the supplemental brief is one that should be addressed after the decision in Armstrong v. Asten-Hill, 90 Or App 200 (1988), and claimant has filed a response to the motion addressing the legal issues. We allow the motion.

The insurer urges that we rate claimant pursuant to the standards adopted by the Director July 1, 1988, and not by the former greenbook guidelines used by the Evaluation Division and the Referee when they rated claimant. This would cause us to use the "clear and convincing evidence" standard of ORS 656.283(7), which states in relevant part:

> "[T]he referee shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Nothing in this section shall be construed to limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the director under ORS 656.726."

The "clear and convincing evidence" test only applies to those cases to which we apply the disability standards adopted by the Director under ORS 656.726. These standards were adopted July 1, 1988 and are applicable to all claims closed on or after that date. See OAR 436-35-003. Moreover, the disability rating standards adopted by the Director apply to hearings conducted on or after July 1, 1988 and only to claims closed and evaluated by the Evaluation Section, insurers, and self-insured employers on and after July 1, 1988, where a claimant last became medically

stationary on and after January 1, 1988. See OAR 438-10-005; Linda L. Carroll, 40 Van Natta 1095 (1988).

Inasmuch as these standards were neither adopted nor effective at the time of hearing, the "clear and convincing evidence" burden of proof does not apply. The proper standard of proof is preponderance. Hutcheson v. Weyerhaeuser, 288 Or 51 (1988).

ORDER

The Referee's order, dated November 19, 1987, is affirmed.

GARY H. HEATON, Claimant
Vick & Gutzler, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-18702
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Baker's order that upheld the insurer's denial of his neck, upper back, and left arm conditions.

The Board reverses the order of the Referee.

ISSUE

Whether claimant sustained a compensable injury to his neck, upper back, and left arm on September 3, 1987.

FINDINGS OF FACT

Claimant began working for the insured, a mobile home manufacturer, in January, 1987. His job was to construct and install the walls of mobile homes. On September 3, 1987, he and a co-worker, Mike Wise, were moving a 450 pound wall when he accidentally backed into a support beam. As the wall pushed into him, his head was forced downward resulting in an injury to his neck, upper back, and left arm. The injury was observed by Wise and two additional witnesses: (1) Carol Townsend, an employee of the insured and claimant's fiance'; and (2) Thomas Miller, a co-worker.

Later that afternoon, claimant accidentally shot himself in the left thigh with a nail gun. He was immediately taken to a hospital and the nail was removed. After several days of bed rest, he returned to regular work on September 14, 1987. As the week progressed, he experienced increased pain in his neck, upper back, and left arm. On September 21, 1987, he sought treatment from Dr. Moore, a chiropractor, for his increased pain. Moore restricted him to light duty work and treated conservatively.

On September 27, 1987, claimant filed an industrial injury claim for his neck, upper back, and left arm conditions. On the claim form, he recorded his date of injury as "3 9 87[.]" This was due to his 20 year military history of recording dates in the order of day, month, and year; i.e., he was, in fact, claiming an injury of September 3, 1987.

Believing that claimant was contending that he had

injured himself on March 9, 1987, the insurer denied the claim on the basis of timeliness. At the hearing, without objection, the insurer amended its denial to include the following additional basis:

> "the evidence does not show that the claimant injured himself in the course and scope of his employment, nor is there a reasonable connection between his employment and his treatment afforded for this alleged condition whatever date he alleges that it happened."

On October 27, 1987, claimant gave a recorded statement to a representative of the insurer. In so doing, he stated that his neck, upper back, and left arm injury occurred on September 18, 1987.

The following month, claimant was examined by Dr. Buza, a neurosurgeon. Upon examination, Buza found pain at the base of the cervical spine. He treated with anti-inflammatory medication and recommended an MRI, which revealed a significant disc protrusion with chord compression at C5-6. A CT scan performed in December, 1987, revealed, inter alia, two substantial osteophytes and bony spurs at C5, as well as significant stenosis of the C6 neural foramen.

CONCLUSIONS OF LAW

Claimant must prove that his neck, upper back, and left arm conditions arose out of and in the course of his employment. ORS 656.005(7)(a). The Referee found that claimant had not met his burden of persuasion. We disagree.

First, claimant's neck, upper back, and left arm injury was observed by three witnesses. Tr. 51, 57, 70. Moreover, the three witnesses, Wise, Townsend, and Miller, corroborated claimant's testimony that the injury occurred on September 3, 1987. Tr. 51, 56, 70.

The insurer argues that all three witnesses are "biased." We disagree. Wise and Miller were friends of claimant. Townsend was claimant's fiance'. While testifying, the three witnesses made no attempt to conceal their relationship to claimant. In sum, we find no persuasive evidence of bias on the part of Wise, Miller, or Townsend.

Second, we agree with the Referee insofar as he found that claimant's notations of an injury of "3 9 87[,]" are explainable by his 20-year military background of recording dates by the day, month, and year. Therefore, he was not asserting that he had injured his neck and left arm on March 3, 1987; but, rather, on September 3, 1987.

Third, we do not find that the insurer's taped statement undermines claimant's credibility. Ex. 6A-6. During that statement, the following exchange took place:

> "Q. Okay. You [claimant] have filed a claim for an on-the-job back and arm injury. What day was that?

"A. On this job?

"Q. Yes.

"A. Okay, uh, I'd have to, let me look at the calendar here 'cause I, I filed actually two claims. The first claim I filed was on the 3rd of September, uh, when I had a 16-penny nail driven into my left leg with a nail gun. I was off 4, 5, 6, 7, 8, 9, 10, 11, went back to work on the 14, worked 14, 15, 16, 17, 18th and I filed for the, uh, the back and neck injury on the 21st of September, so I went to the doctor for it. The accident actually happened on the 18."

At the hearing, claimant was confronted with the above prior statement and offered a persuasive explanation:

"Q. Do you remember telling [the insurer's representative] that it -- that your injury regarding the neck occurred on 9/18?

"A. No, sir I don't. Unless it was it -- unless it was whenever I took a recorded statement or whatever."

"Q. Well, the difference between 9/3 and 9/18 is 15 days.

"A. 9/18 sir, is whe -- is when I left work. I was already on workmen's comp with the nail -- 9/18, sir, is when I'd left work. I'd worked that day and that was the date that -- the last day that I worked, so I assumed, sir, that that'd been -- that was the question. 'When did injury occur?' And I assumed if I left work on 9/18, that's when I would have claimed it."

Fourth, during the course of an injured worker's claim, he is often repeatedly required to describe the industrial injury. This case is no exception. Claimant provided a description of his injury on the claim form, Ex. 1, on two forms at Dr. Moore's office, Exs. 2 & 3, in his taped statement to the insurer, Ex. 6A-7, in a history to Dr. Buza, Ex. 9-1, and at the hearing. Tr. 14. After reading all of those descriptions we conclude that they are substantially consistent. We disagree with the Referee's finding that after September 21, 1987, claimant "substantial[ly] change[d]" his description of the injury.

In our view, <u>substantial change</u> must be distinguished from subsequently rendering a <u>more complete description</u>. That is, at Dr. Moore's office, claimant reported that the wall "fell against my back & neck." Ex. 2A & 4. A few days later, he reported that he was "pushed into support beam by end wall." Ex. 1. His first opportunity to provide a verbal description was during his taped statement to the insurer. Ex. 6A-7. That verbal description is not only consistent with his testimony at the hearing, as corroborated by Wise, Miller, and Townsend, but it

also shows that the wall, in fact, "fell" against him or "pushed" him into a support beam. Therefore, his descriptions before and after September 21, 1987, are consistent.

Last, we turn to the medical evidence. Dr. Moore's opinion is unrebutted. Moore reported, inter alia:

> "It is my professional opinion that the problems that [claimant] presently has are due directly to the injury dated September 3, 1987, at [the insured]. Dr. Buza in his reports also stated that the injuries were due to the work at the [insured]."
>
> "* * * The accident happened. The extremely heavy lifting that is necessary in the work that [claimant] was doing is the most important factor and the causative reason for his problems." (Emphasis added).

In our view, Dr. Moore has rendered an opinion within a reasonable degree of medical probability that claimant's injury of September 3, 1987, "directly" contributed to his neck, upper back, and left arm conditions. The fact that he later mentions "heavy lifting" must be read within the context of his entire opinion. Moreover, the injury of September 3, 1987, could correctly be viewed as occurring during "heavy lifting." That is, claimant and Wise were pushing and pulling an end wall weighing approximately 450 pounds. Ex. 6A-7.

Accordingly, we conclude that claimant has proven that he sustained an injury to his neck, upper back, and left arm on September 3, 1987, which arose out of and in the course of employment requiring medical services.

ORDER

The Referee's order, dated April 7, 1988, is reversed. The insurer's denial is set aside and it shall process claimant's claim according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the insurer. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,114.

WANDA J. JARRETT, Claimant	WCB 86-09660
Ginsburg, Gomez & Neal, Claimant's Attorneys	October 25, 1989
Beers, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

EBI Companies requests review of those portions of Referee Smith's order that: (1) set aside its denial of claimant's aggravation claim relating to her right wrist; and (2) directed it to pay an associated attorney fee. In her respondent's brief, claimant contends that the Referee erred in failing to assess a penalty and associated attorney fee against EBI for unreasonable denial of her aggravation claim. We affirm.

ISSUES

1. Aggravation of claimant's right wrist condition.

2. Attorney fee in connection with the aggravation denial.

3. Penalty and attorney fee for unreasonable denial of the aggravation claim.

FINDINGS OF FACT

Claimant worked for the employer, a rifle scope manufacturer, as an assembler. In July 1984, she began to experience pain and swelling in her right wrist and thumb, but was able to continue working. She first sought medical treatment for the condition in October 1984 from Dr. Korchinski, an internist. EBI Companies (EBI) was the employer's insurer during 1984 and early 1985.

In November 1984, claimant underwent noncompensable abdominal surgery and was off work for several months. Her wrist continued to bother her during this period. She returned to work in late January 1985 and her wrist pain increased. In addition, she began to experience numbness and tingling in the fingers of her right hand. In March 1985, she filed a claim for a "wrist/thumb sprain/strain." EBI accepted the claim as a nondisabling injury and apparently issued a Notice of Closure shortly thereafter. Neither the claim form nor any of the medical reports through the date of EBI's acceptance mentioned claimant's fingers or the symptoms in her fingers.

Claimant continued to work as an assembler until May 1985, when she began working as a messenger for the employer. Safeco Insurance Company (Safeco) became the employer's insurer on April 1, 1985. Claimant's wrist condition improved while she worked as a messenger, but never fully resolved. The numbness and tingling in her fingers disappeared, however.

In February 1986, claimant returned to work as an assembler. During the next several weeks, she experienced an increase in right wrist pain and the numbness and tingling in her fingers returned. She also experienced pain in her right elbow. She sought treatment from Dr. Korchinski, who referred her to Dr. Neitling, an orthopedic surgeon. Dr. Neitling ordered a number of diagnostic tests and his ultimate diagnoses were de Quervain's tenosynovitis, a dorsal ganglion and early osteoarthritis. The cause of the numbness and tingling in claimant's fingers was never identified. The right elbow symptoms were caused by pain referred from the compensable wrist condition. Claimant left work as a result of her right wrist condition on March 19, 1986 and remained off work for more than 14 days. Dr. Neitling and Dr. Platt, a neurologist, both opined that claimant's work activity after April 1, 1985 did not pathologically worsen her right wrist condition.

Claimant filed an occupational disease claim against Safeco on March 17, 1986. Safeco issued a denial of compensability and responsibility the following week. Claimant failed to request a hearing on this denial within 60 days. She then filed an aggravation claim against EBI. EBI issued a compensability denial on June 10, 1986 and requested the designation of a paying agent under <u>former</u> ORS 656.307. Claimant timely requested a hearing on that denial. In April 1986, Safeco and claimant entered into a disputed claim settlement regarding

the Safeco claim and claimant's request for hearing on that claim was dismissed with prejudice. Because of this, issuance of a .307 order was denied. EBI nonetheless asserted responsibility, in addition to compensability, as a defense at the hearing.

FINDINGS OF ULTIMATE FACT

1. Claimant's work activity in early 1986 caused a worsening of the symptoms of her right wrist condition. It also caused symptoms in claimant's right elbow due to referral of pain from the wrist. The worsening of the symptoms of the right wrist condition resulted in a reduced ability to work. Claimant's work activity after April 1, 1985 did not worsen her underlying right wrist condition. The symptoms in the fingers of claimant's right hand were unrelated to her compensable right wrist condition.

2. Claimant's entitlement to receive compensation was at risk at the hearing.

3. EBI's denial of claimant's claim for aggravation was not unreasonable.

CONCLUSIONS OF LAW

1. Aggravation

The Referee concluded that claimant experienced a symptomatic worsening of de Quervain's tenosynovitis in early 1986 and set aside EBI's aggravation denial with respect to that condition. He upheld the denial with respect to the numbness and tingling in claimant's fingers on the theory that the unidentified condition causing those complaints was severable from the de Quervain's tenosynovitis and first arose after Safeco came on the risk. On Board review, EBI contends that it should be relieved of responsibility for claimant's de Quervain's tenosynovitis under the last injurious exposure rule. In the alternative, it contends that the increased symptoms experienced by claimant in early 1986 were not attributable to de Quervain's tenosynovitis and thus that claimant has failed to prove a compensable aggravation.

In view of the fact that EBI was the sole insurer at the time of the hearing, its assertion of the last injurious exposure rule as a defense raises the question of the applicability of Runft v. SAIF, 303 Or 493 (1987). We need not decide this question, however, because even if Runft is inapplicable, EBI is responsible under the last injurious exposure rule.

EBI's primary argument under the rule is that claimant experienced new symptoms in her right arm and hand in 1986 and that those new symptoms establish a worsening of her underlying right wrist condition. The new symptoms cited by EBI are pain in claimant's right elbow and numbness and tingling in the middle three digits of her right hand. We reject EBI's argument for several reasons. First, the record reflects and we have found as fact that the symptoms in the middle three fingers of claimant's right hand began while EBI was still on the risk in early 1985. EBI's characterization of the symptoms as new to the period of Safeco's coverage, therefore, is erroneous. Second, we agree with the Referee on the record as developed that the undiagnosed condition causing numbness and tingling in the fingers of claimant's right hand is severable from and unrelated to her

de Quervain's tenosynovitis. A worsening of that condition, therefore, would not absolve EBI of responsibility for the wrist condition. Third, even under the assumption that the finger symptoms first appeared in 1986 and that they were related to claimant's compensable right wrist condition, Drs. Neitling and Platt both opined that they did not represent a worsening of claimant's underlying condition.

The symptoms in claimant's right elbow did first occur in early 1986. They resulted from referral of pain from claimant's compensable wrist condition to her elbow and thus are part of the compensable condition. Again, however, both Drs. Neitling and Platt opined that the elbow symptoms did not represent a worsening of claimant's underlying wrist condition.

EBI also argues that Safeco is responsible under the last injurious exposure rule because claimant's de Quervain's tenosynovitis became asymptomatic during late 1985 and then became symptomatic in early 1986. This argument is based on erroneous factual and legal premises. Claimant's condition never became totally asymptomatic between early 1985 and early 1986 and, in any event, a worsening of symptoms without a concomitant worsening of the underlying condition is insufficient to assign responsibility to the new injury carrier. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986). On this record, we conclude that EBI is responsible for claimant's condition under the last injurious exposure rule.

Turning to the issue of compensability, claimant must prove a worsened condition, as a matter of fact, resulting from the original injury. Perry v. SAIF, 307 Or 654 (1989); ORS 656.273(1). In addition, she must prove that her worsened condition, which may take the form of either an objective change in her underlying condition or a flare-up in symptoms, caused her to become more disabled, i.e., less able to work. Smith v. SAIF, 302 Or 396, 399 (1986). If her worsened condition took the form of a symptomatic flare-up, she must further prove that her flare-up exceeded that which was contemplated at the time of the last arrangement of compensation. Gwynn v. SAIF, 304 Or 345, on rem 91 Or App 84 (1988).

Here, EBI accepted claimant's original 1985 claim for a right wrist/thumb "sprain-strain[,]" as a nondisabling injury. After changing job duties and briefly working as a messenger, claimant returned to her at-injury assembler job in February, 1986. In a few weeks, her right wrist pain returned accompanied by pain in her elbow and hand. As we found above, her elbow pain -- but not her hand pain -- was caused by her wrist condition. As a result of her increased pain and symptoms, she became temporarily less able to work.

Under such circumstances, we conclude that claimant sustained a symptomatic flare-up of her de Quervain's tenosynovitis condition in March, 1986. Unlike the situation in Gwynn, however, we find an absence of evidence at the time of EBI's Notice of Closure, i.e., the last arrangement of compensation, indicating a likelihood of future symptomatic flare-ups. See Gwynn, 94 Or App at 88. Accordingly, inasmuch as we find that the parties did not contemplate future symptomatic flare-ups at the time of the Notice of Closure, we need not address the Gwynn issue of whether claimant's flare-up exceeded that which was contemplated. The relevant inquiry, therefore, is

whether claimant's symptomatic flare-up reduced her ability to work. Smith, supra. We conclude that it did, inasmuch as she became temporarily unable to work on March 19, 1986, as a result of her 1985 compensable right wrist condition.

EBI argues that claimant's de Quervain's tenosynovitis was due to the noncompensable undiagnosed condition causing the numbness and tingling in the fingers of her right hand. The fact that the noncompensable condition affecting claimant's fingers may also have contributed to claimant's disability does not defeat the aggravation claim. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

In sum, we conclude that claimant has established a factual worsening of both her right wrist and elbow conditions resulting from the compensable 1985 injury. She has not proven, however, a material causal connection between her right hand symptoms and the 1985 injury.

2. Attorney Fee in Connection with the Aggravation Denial

The Referee ordered EBI to pay an attorney fee to claimant's attorney for the attorney's efforts in setting aside EBI's aggravation denial. EBI contends that it is not responsible for the attorney fee under the rule of Karen J. Bates, 39 Van Natta 42 (1987). We disagree.

EBI's aggravation denial expressly denied the "compensability" of claimant's claim. Ex. 38-1. Although the language of its denial can be construed as also indicating an intent to deny responsibility, that does not abrogate the plain and unambiguous denial of "compensability." If EBI had denied solely responsibility then the issue of compensability would be moot. This would be because EBI, by the nature of a responsibility denial, would have implicitly conceded a compensable aggravation. However, EBI's arguments to the Referee and the Board do not indicate such an intent. Therefore, we conclude that claimant's attorney was entitled to an assessed fee for services at hearing pursuant to ORS 656.386(1), payable by EBI.

Claimant's attorney is also entitled to a fee payable by EBI for services rendered on Board review. ORS 656.382(2). No fee may be awarded at this time, however, because claimant's attorney has not submitted a statement of services in accordance with OAR 438-15-010(5).

3. Penalty and Attorney Fee for Unreasonable Denial

A penalty and associated attorney may be assessed against a carrier which "unreasonably refuses to pay compensation." ORS 656.262(10), 656.382(1). Claimant contends that EBI's denial of her aggravation claim was unreasonable. We disagree. The effect of claimant's work activity after Safeco came on the risk was not clear until after the post-hearing depositions of Drs. Neitling and Platt. No penalty or associated attorney fee is warranted under these circumstances.

ORDER

The Referee's order dated December 7, 1987, as amended by the order dated March 8, 1988, is affirmed.

MOHAMMAD A. KAROUT, Claimant
John E. Uffelman, Claimant's Attorney
Roberts, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 89-05362 & 89-03949
October 25, 1989
Order of Dismissal

Underwriting Adjustment Company (UAC) has moved the Board for an order dismissing claimant's request for review on the ground that it did not receive timely notice of the request. The motion is granted.

FINDINGS

The Referee's Opinion and Order issued July 12, 1989. The Referee's order contained two WCB Case numbers. i.e., 89-03949 and 89-05362. Pursuant to the order, UAC's Notice of Closure was affirmed, UAC's denial of claimant's aggravation claim was upheld, Kemper Insurance Company's denial of claimant's "new injury" claim for right neck and trapezius symptoms was set aside insofar as it denied responsibility for these symptoms until February 10, 1989, and claimant's attorney was awarded a reasonable assessed fee to be paid by Kemper.

On August 4, 1989, claimant mailed by certified mail a request for Board review of the Referee's order. Listing only the WCB Case number which pertained to claimant's claim with Kemper, the request stated that claimant was seeking "review of the order terminating and limiting Kemper's responsibility as of February 10, 1989." The request included a certificate of personal service by mail upon Kemper, its insured, and its attorney. The request did not include an acknowledgment of service or a certificate of personal service by mail upon UAC, its insured, or its attorney.

On August 10, 1989, the Board mailed a computer-generated letter to all parties to the proceeding before the Referee acknowledging the request. The acknowledgment carried both WCB Case numbers. Counsel for UAC received this acknowledgment on August 15, 1989. The receipt of the Board's acknowledgment letter constitutes UAC's first notice of claimant's request for Board review.

On August 25, 1989, the Referee issued an amended order. Pursuant to that order, a client-paid fee, payable from UAC to its counsel, was approved.

ULTIMATE FINDINGS

The Referee's decisions in WCB Case Nos. 89-05362 and 89-05362 were contained in one order, dated July 12, 1989. Claimant's request for review was mailed to the Board within 30 days of the Referee's July 12, 1989 order. However, all parties to the proceeding did not receive notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for

review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id.

Here, the 30th day after the Referee's July 12, 1989 order was August 11, 1989. Claimant's request for Board review was filed August 4, 1989, the date he mailed the request by certified mail. See OAR 438-05-046(1)(b). Consequently, claimant's request for review was timely mailed to the Board. See ORS 656.289(3).

However, the record fails to establish that all parties to the proceeding before the Referee were either provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Instead, pursuant to UAC's counsel's affidavit, UAC's first notice of claimant's request occurred on August 15, 1989, when UAC's counsel received the Board's August 10, 1989 acknowledgment letter. August 15, 1989 is more than 30 days after the Referee's July 12, 1989 order.

Claimant admits that copies of his request for review were not provided to UAC, its insured, and its counsel. Yet, he asserts that such an omission is not fatal to our retaining jurisdiction because he seeks to challenge only that portion of the Referee's July 12, 1989 order which pertained to Kemper. i.e., WCB Case No. 89-05362. We disagree with claimant's assertion.

Although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. William E. Wood, 40 Van Natta 999 (1988). Furthermore, because UAC was a party to the Referee's order, it remains a party to the proceeding on Board review. See William E. Wood, supra; James G. Adams, 38 Van Natta 1318 (1986).

Finally, since the Referee's amended order issued more than 30 days after the July 12, 1989 order, the Referee lacked jurisdiction to modify, abate, stay or republish his initial order insofar as it pertained to the merits of the claim. See ORS 656.289(3); Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35, n. 3 (1988); Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986); International Paper Co. v. Wright, 80 Or App 444, 447 (1986); Leon C. Buzard, 40 Van Natta 595 (1988). Consequently, the Referee was without authority to extend the parties' 30-day rights of appeal from the July 12, 1989 order.

In conclusion, because UAC was a party to the proceeding before the Referee and since neither it nor its representatives received notice of claimant's request for Board review within 30 days of the Referee's July 12, 1989 order, we lack jurisdiction to

review the Referee's order. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

MARC D. MARDIS, Claimant
Francesconi & Cash, Claimant's Attorneys
Judy Johnson (SAIF), Defense Attorney

WCB 87-04438
October 25, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

The SAIF Corporation requests review of Referee Leahy's order that: (1) found that it had improperly terminated claimant's temporary disability payments, while he was incarcerated; and (2) awarded a $1500 insurer-paid attorney fee for prevailing at the hearing. On review, the issues are entitlement to temporary disability compensation and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to his right wrist in January 1983. Claimant has undergone two bone grafts on his right wrist, the first in April 1986 and the second in January 1987. Claimant has not been declared medically stationary, nor has he been released for work. The claim remains in an open status.

On January 26, 1987, claimant was incarcerated.

SAIF learned of claimant's incarceration on March 2, 1987. The following day, SAIF advised him that his benefits would be suspended. SAIF's letter further advised claimant to contact SAIF if he was not incarcerated. Claimant was also advised that he had a right to an expedited hearing to contest the termination of benefits.

SAIF's claim examiner spoke with claimant on March 6, 1987, at which time claimant acknowledged his incarceration. On March 12, 1987, SAIF terminated claimant's temporary disability payments.

CONCLUSIONS OF LAW

There is no dispute as to the facts. Claimant is not medically stationary, he has not been released to work, and his claim has not been closed. Despite this, SAIF unilaterally terminated claimant's temporary disability benefits on the basis of claimant's incarceration.

In Lloyd O. Fisher, 39 Van Natta 5 (1987), the Board held that an unilateral termination of temporary disability benefits, solely on the basis that claimant is incarcerated, is invalid. This rationale has been sustained by the Court of Appeals. Northrup King & Co. v. Fisher, 91 Or App 602 (1988). Accordingly, we agree with the Referee's conclusion that SAIF's termination of temporary disability benefits was improper.

We modify the Referee's order with regard to claimant's

attorney fee. Claimant is not entitled to an ORS 656.386(1) attorney fee because the Referee awarded additional compensation for temporary disability.

Former OAR 438-47-030 provided:

> "If, after a hearing requested by the claimant, the referee awards additional compensation for temporary disability, the referee shall approve a fee of 25 percent of the increased compensation, but not more than $750, to be paid out of the increased compensation."

Therefore, claimant's attorney was not entitled to an assessed carrier-paid fee for his services at hearing, but rather, an approved fee, equal to 25 percent of the increased temporary disability compensation, not to exceed $750.

ORDER

The Referee's order dated July 14, 1987 is affirmed in part and modified in part. In lieu of the Referee's award of an insurer-paid attorney fee, claimant's attorney is awarded 25 percent of the increased compensation created by the Referee's order, payable out of that compensation, not to exceed $750. In the event that the compensation awarded by the Referee has already been paid to claimant, the SAIF Corporation shall pay the aforementioned fee directly to claimant's attorney. Since such an action, in effect, creates an overpayment of claimant's compensation, SAIF is authorized to recover the overpayment against claimant's future awards of permanent disability. The remainder of the Referee's order is affirmed. For services on Board review concerning the unilateral termination issue, claimant's attorney is awarded $600, to be paid by the SAIF Corporation.

JACK NEALY, Claimant	WCB 86-02885
Olson, et al., Claimant's Attorneys	October 25, 1989
Cowling & Heysell, Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Mongrain's order that: (1) declined to grant claimant permanent total disability; and (2) affirmed a Determination Order award of 100 percent (192 degrees) scheduled permanent disability for bilateral hearing loss. The issue on review is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant, 58 years old at hearing, sustained compensable and virtually total bilateral hearing loss while employed as a mill worker by the self-insured employer. He also suffers from tinnitus and intermittent vertigo related to his hearing loss. The profound deafness has been present since at least early 1981.

Claimant continued to work full time for the employer

until the mill was shut down in May 1984. Between that time and January 1985, he looked for work at a number of different mills and at a cemetery where he knew the owner; however the mills were not hiring and he was unsuccessful locating a position. He received unemployment compensation during this time.

In January 1985, claimant applied for social security disability benefits, which he began to receive in February 1985. He has not looked for work since that time.

A January 29, 1986 Determination Order awarded claimant 100 percent scheduled permanent disability for bilateral hearing loss.

Claimant has a ninth grade education. Virtually all of his work experience since 1949 has been in mills. He has transferable skills as a result of this employment. He has never had a course in sign language. At hearing he responded to written questions. He has a driver's license and drives when he feels up to it and when in company with other people. He also drives a snowmobile and hunts. At times, he goes to the store by himself and purchases things.

Claimant is able to regularly perform work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Opinion with the following supplementation.

Claimant does not contend, nor does the evidence establish, that he is completely physically disabled as a result of his hearing loss alone. Rather, he contends that he is entitled to an award of permanent total disability under the "odd lot" doctrine. See Wilson v. Weyerhaeuser, 30 Or App 403 (1977). We consider the factors of age, education, adaptability to other labor, mental condition, and emotional status. If a combination of these factors make it improbable that claimant could ever enter the work force, we may find him permanently totally disabled. Claimant has the burden of proving that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. 656.206(3).

Claimant relies on the opinion of Dr. Pfendler, otolaryngologist, that claimant is unemployable because of his hearing loss and age. However, we give less weight to a medical opinion regarding vocational issues, because such issues are outside this physician's specialty. We find the opinions of the vocational counselors that claimant is employable to be more persuasive than Dr. Pfendler's opinion that other employers will not hire claimant because of his hearing loss.

Claimant was essentially completely deaf in 1981, but continued at his regular employment until 1984. At that time, he was laid off for reasons unrelated to his compensable condition. Here, two vocational counselors testified that while the economic conditions in claimant's area are depressed, there are jobs he could perform in that labor market, as well as in a normal labor market. Furthermore, the vocational counselors support the conclusion that, while there are safety and communication concerns

for some jobs claimant has performed in the past, he does have transferable skills. Inasmuch as we consider these opinions persuasive, we conclude that claimant is not permanently incapacitated from regularly performing work at a gainful and suitable employment. Accordingly, we agree with the Referee that claimant is not entitled to an award of permanent total disability.

ORDER

The Referee's order dated May 20, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $357.

LORRAINE M. PERSON, Claimant
Tharp & Van Atta, Claimant's Attorneys
Yturri, Rose, et al., Defense Attorneys

WCB 87-04083
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Leahy's order that set aside its denial of claimant's occupational disease claim for a hepatitis condition.

The Board reverses the order of the Referee.

ISSUE

Whether claimant's work exposure, when compared to similar non-work exposure, was the major contributing cause of either the onset or worsening of her hepatitis condition.

FINDINGS OF FACT

Claimant, 59 at the hearing, worked as a scrub nurse at the insured, a hospital, for approximately 20 years before retiring in May, 1986. In 1974, she had an hysterectomy. Shortly thereafter, she developed flu-like symptoms and tested positive for hepatitis. She apparently contracted the hepatitis from a blood transfusion during the course of her hysterectomy. After six weeks off work, her symptoms resolved.

In April, 1986, claimant experienced a recurrence of flu-like symptoms. She missed a few days of work. Her symptoms worsened the following month, a few hours after eating dinner at a restaurant. She consulted her family physician, Dr. Scott. Scott suspected a viral condition and referred her to Dr. Stark, an internist. Although Stark initially diagnosed hepatitis "B," Ex. 6-1, he later agreed that liver biopsy studies indicated "non-A, non-B" hepatitis. Ex. 6-5. According to Stark, claimant probably contracted her present hepatitis condition while performing her nursing duties.

In September, 1986, Dr. Scott referred claimant to Dr. Rosoff, a specialist in liver and biliary tract disorders. Rosoff scheduled claimant for a liver biopsy. After reviewing the biopsy results, Rosoff diagnosed chronic "non-A, non-B" hepatitis. In Rosoff's view, claimant's present hepatitis condition is a recurrence of her 1974 post-transfusion hepatitis.

Claimant was next examined by Dr. Kamin, M.D., in May, 1987. After performing additional liver biopsy studies, Kamin concurred with Dr. Rosoff's findings.

As a scrub nurse, claimant assisted in surgical procedures. To protect herself from infection, she wore a gown and surgical gloves. At times, however, she would get blood inside her gloves or on exposed areas of her skin, such as her face. In addition, she would occasionally perform her duties with minor cuts on her hands. It was a common occurrence to get holes in her gloves during the course of her work. When she discovered any such holes, she complied with the insured's procedure to immediately obtain a new set of gloves.

It was the insured's established procedure for employes to immediately report any needle stick or sharp instrument accidents. Claimant was aware of that procedure and never failed to comply with it. The insured's medical records reveal no report of a needle stick or sharp instrument accident to claimant from May, 1985 through May, 1986. Nor do they reveal a case of hepatitis among patients with whom claimant worked.

ULTIMATE FINDINGS OF FACT

Claimant did not accidentally stick herself with a needle or any other sharp object contaminated by a patient's hepatitis-infected blood. No patient that was assigned to claimant's care was infected with hepatitis.

There is no known, documented, or identifiable hepatitis exposure to claimant during the course of her employment with the insured.

It is undisputed that claimant was exposed to and contracted hepatitis in 1974, unrelated to her work activities.

CONCLUSIONS OF LAW

Despite finding that "there was no record of any [work] incident/exposure to cause hepatitis[,]" the Referee concluded that claimant had proven compensability. We disagree.

ORS 656.802(1)(a) provides, inter alia, that an occupational disease must: (1) arise out of and in the course of employment; and (2) be one to which the worker is not ordinarily subjected or exposed other than during a period of regular actual employment. See also Dethlefs v. Hyster Co., 295 Or 298 (1983).

Here there is no evidence of actual work exposure to the disease at issue; i.e. hepatitis. In essence, claimant's case, as well as Dr. Stark's opinion, rest upon mere speculation that she contracted her present hepatitis while performing her nursing duties. We, however, are not persuaded by such speculation especially when, as here, there is undisputed evidence that claimant was previously exposed to and contracted hepatitis off-the-job.

We look to the recent case of Moore v. Douglas County, 92 Or App 255 (1988), for instruction. On de novo review, the Moore court reversed the Board and found that the worker had proven both legal and medical causation of her occupational disease claim for hepatitis. In so doing, the court stated, inter alia:

> "The evidence is uncontroverted that [the worker] regularly came in contact with bodily fluids of inmates which are potential sources of the hepatitis virus, that inmates and staff in her work place had the disease, that claimant's needle prick incident was a potential means of contracting the virus and that her symptoms appeared within the incubation period for the disease after the incident. There was no evidence of any off-work exposure to the disease." 92 Or App 258.

In our view, the teaching of Moore is that given similar facts of actual work exposure, i.e., legal causation, a physician's failure to use the "magic words" "reasonable medical probability" is not a bar to finding medical causation. 92 Or App at 258. However, we find that Moore is distinguishable from the instant case on its facts. First, there is no evidence that "a number of" patients and staff had hepatitis. 92 Or App at 257. Second, there is no evidence that claimant accidentally pricked herself with a "bloody syringe[]." 92 Or App at 257. Third, there is no evidence that claimant's symptoms arose within the incubation period following a specific on-the-job incident. Last, there is evidence of actual off-the-job exposure to and contraction of hepatitis.

In sum, before reaching the issue of medical causation, we find that, unlike the case in Moore, claimant has failed to prove legal causation.

In the light of Moore, we nonetheless proceed to address the issue of medical causation. The medical evidence is divided between Drs. Rosoff and Stark. Both physicians have stated their respective opinion in terms of a reasonable medical probability. (Exs. 36 & 38-11 thru 12). Moreover, both physicians began treating claimant on referral from Dr. Scott: Stark in May, 1986, and Rosoff in September, 1986. We, therefore, decline to assign greater weight to either of their opinions on the sole basis that one of them, and not the other, was claimant's "treating physician." See Weiland v. SAIF, 64 Or App 810 (1983).

Dr. Rosoff, a specialist in liver disorders, performed liver biopsy studies and correctly diagnosed "non-A, non-B" hepatitis. According to Rosoff, of the three types of hepatitis, i.e., "A," "B" and "non-A, non-B," the latter has the highest likelihood of chronicity. He is of the opinion that "the most probable source of [claimant's] chronic hepatitis is the post-transfusion hepatitis that she suffered in 1974." In May, 1987, Dr. Kamin seemingly reached the same diagnosis and conclusion, stating:

> "DIAGNOSIS: Compatible with mild chronic active hepatitis (? chronic active hepatitis in remission).
>
> "COMMENT: There is portal hepatitis with some proliferation of ducts and ductules and mild periportal hepatitis with appreciable portal and periportal fibrosis. The lobules show mild fatty

change and an occasional Councilman body." (Ex. 29-15).

Dr. Stark, however, opines that claimant's present hepatitis is a result of work exposure to hepatitis. As we understand his opinion, he recognizes three "possible" etiologies: (1) recurrence of the off-the-job 1974 post-transfusion hepatitis; (2) off-the-job food exposure in May, 1986; and (3) on-the-job exposure. He rules out possibility "(1)" on the basis that claimant was symptom free from hepatitis for approximately 12 years and on results from the liver biopsy studies, which, in his view, showed insufficient scarring of chronic hepatitis. We are not persuaded by Stark's opinion.

First, Dr. Stark initially misdiagnosed claimant's condition as hepatitis "B." Only after Dr. Rosoff performed liver biopsy studies and diagnosed hepatitis "non-A, non-B" did Stark alter his initial diagnosis to concur with Rosoff. Second, unlike Stark, Rosoff has unique expertise specifically within the field of chronic liver diseases vis-a-vis hepatitis. (Ex. 37). Last, after performing additional liver biopsy studies, Dr. Kamin seemed to concur with Rosoff's opinion that claimant's hepatitis was a recurrence of her 1974 infection.

Accordingly, on this record, and especially considering claimant's prior off-the-job exposure to and actual off-the-job contraction of hepatitis, we are not persuaded that her work exposure, when compared to her non-work exposure, was the major contributing cause of either the onset or worsening of her hepatitis condition.

ORDER

The Referee's order, dated February 5, 1988, is reversed. The insurer's denial is reinstated and upheld. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $895.50.

JAMES F. RICHARDSON, Claimant	WCB 87-10811
Haugh & Foote, Claimant's Attorneys	October 25, 1989
David O. Horne, Defense Attorney	Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Smith's order that: (1) set aside its denial of claimant's injury claim for an ankle condition; and (2) awarded an insurer-paid attorney fee of $1,400. The issues on review are compensability and attorney fees. We affirm.

FINDINGS OF FACT

Claimant is a hyster driver. He has suffered from an ingrown toenail on his left large toe for some time. On the morning of June 29, 1987, the toe was bothering him and caused him to limp on his way to work. Shortly after work started, he attempted to dismount from his hyster without putting pressure on his left large toe. In doing so, he struck his right foot on the hyster or on a piece of wood on the ground and sprained his right ankle.

An ice pack was placed on the ankle and he rested his

leg on a chair in the breakroom until his wife arrived to take him to the doctor. On July 14, 1987, Dr. Duff reported he had a swollen and tender ankle and directed claimant to wear an ankle brace. He diagnosed an inversion injury. He released claimant to regular work, on July 28, 1987.

Claimant is a credible witness. The testimony of the other witnesses at hearing was generally consistent with claimant's testimony.

ULTIMATE FINDINGS OF FACT

Claimant injured his right ankle in the course and scope of his employment.

An insurer-paid attorney fee of $1,400 is reasonable.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant to be a credible witness. We agree. The insurer invites us to find that claimant injured his ankle while off the job. There is no evidence to support such a finding. Claimant offered a rational explanation of why he was limping before the accident; there is no evidence, medical or otherwise to rebut that explanation.

The insurer also argues that the Referee's award of $1,400 to claimant's attorney for services at hearing is excessive. We review awards of attorney fees pursuant to OAR 438-15-010(6). That rule sets forth the following considerations for determining attorney fees: time devoted to the case; complexity of the issue(s) involved; the value of the interest involved; the skill and standing of the attorneys; the nature of the proceedings; the result secured for the represented party; the risk that an attorney's efforts may go uncompensated; and the assertion of frivolous issues.

Here, claimant prevailed against a denial of compensability on an injury claim. The case was not of extraordinary length or complexity. The value of the interest involved is larger than the medical bills and time loss; the establishment of compensability creates aggravation rights for claimant and lifetime medical benefits for this condition. The risk of claimant's attorney not being compensated was average or higher. When we consider all the factors, we find the award of the Referee to be reasonable. See Barbara A. Wheeler, 37 Van Natta 122 (1985).

ORDER

The Referee's order, dated October 15, 1987, is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded a reasonable fee of $500, to be paid by the insurer.

MARK S. RICHARDSON, Claimant
Heiling & Morrison, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-09036
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Huffman's order which found that his claim for a back injury had not been closed prematurely by a Determination Order. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

Claimant worked as a green chain offbearer for the employer for approximately one year. In March 1987, he sustained a compensable injury to his left back. Following the injury, claimant sought treatment from Dr. Damond, chiropractor. Dr. Damond released claimant to modified work on March 12, 1987. On March 17, 1987, following complaints by claimant of increasing back pain, Dr. Damond recommended that claimant be given an alternate light duty position which the employer had available.

On March 19, 1987, claimant sought treatment from Dr. Herscher, osteopath. He prescribed medication and released claimant for modified work. Claimant returned to his regular work on April 9, 1987. He was discharged by his foreman on April 13, 1987. Claimant was capable of performing his regular duties, but continued to experience back pain. In May 1987, claimant again sought treatment from Dr. Damond.

The claim was closed by Determination Order on July 7, 1987. The Determination Order awarded claimant temporary partial disability from March 13, 1987 through April 9, 1987. There was no award of permanent partial disability.

CONCLUSIONS OF LAW

The Referee found that claimant was medically stationary on April 9, 1987 based on the fact that claimant was released to regular work as of that date. We disagree.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that his claim was prematurely closed. Austin v. SAIF, 48 Or App 7 (1980). In determining whether a claim has been properly closed, a determination of whether a claimant was medically stationary on the date of closure must be made, without considering subsequent changes in his or her condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, medical reports authored after closure may be considered where there has been no post-closure change in claimant's condition and the only question is whether claimant was stationary at the time of closure. Wojick v. Weyerhaeuser Co., 89 Or App 561 (1987); Scheuning v. J.R. Simplot Co., 84 Or App 622 (1987).

Here, we are not persuaded that claimant was medically stationary on April 9, 1987, the date he was given a full release to work by Dr. Herscher, or on July 7, 1987, the date of claim closure. In August 1987, Dr. Damond reported that claimant was not medically stationary and had not fully recovered from the injury

leg on a chair in the breakroom until his wife arrived to take him to the doctor. On July 14, 1987, Dr. Duff reported he had a swollen and tender ankle and directed claimant to wear an ankle brace. He diagnosed an inversion injury. He released claimant to regular work, on July 28, 1987.

Claimant is a credible witness. The testimony of the other witnesses at hearing was generally consistent with claimant's testimony.

ULTIMATE FINDINGS OF FACT

Claimant injured his right ankle in the course and scope of his employment.

An insurer-paid attorney fee of $1,400 is reasonable.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant to be a credible witness. We agree. The insurer invites us to find that claimant injured his ankle while off the job. There is no evidence to support such a finding. Claimant offered a rational explanation of why he was limping before the accident; there is no evidence, medical or otherwise to rebut that explanation.

The insurer also argues that the Referee's award of $1,400 to claimant's attorney for services at hearing is excessive. We review awards of attorney fees pursuant to OAR 438-15-010(6). That rule sets forth the following considerations for determining attorney fees: time devoted to the case; complexity of the issue(s) involved; the value of the interest involved; the skill and standing of the attorneys; the nature of the proceedings; the result secured for the represented party; the risk that an attorney's efforts may go uncompensated; and the assertion of frivolous issues.

Here, claimant prevailed against a denial of compensability on an injury claim. The case was not of extraordinary length or complexity. The value of the interest involved is larger than the medical bills and time loss; the establishment of compensability creates aggravation rights for claimant and lifetime medical benefits for this condition. The risk of claimant's attorney not being compensated was average or higher. When we consider all the factors, we find the award of the Referee to be reasonable. See Barbara A. Wheeler, 37 Van Natta 122 (1985).

ORDER

The Referee's order, dated October 15, 1987, is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded a reasonable fee of $500, to be paid by the insurer.

MARK S. RICHARDSON, Claimant
Heiling & Morrison, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-09036
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Huffman's order which found that his claim for a back injury had not been closed prematurely by a Determination Order. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

Claimant worked as a green chain offbearer for the employer for approximately one year. In March 1987, he sustained a compensable injury to his left back. Following the injury, claimant sought treatment from Dr. Damond, chiropractor. Dr. Damond released claimant to modified work on March 12, 1987. On March 17, 1987, following complaints by claimant of increasing back pain, Dr. Damond recommended that claimant be given an alternate light duty position which the employer had available.

On March 19, 1987, claimant sought treatment from Dr. Herscher, osteopath. He prescribed medication and released claimant for modified work. Claimant returned to his regular work on April 9, 1987. He was discharged by his foreman on April 13, 1987. Claimant was capable of performing his regular duties, but continued to experience back pain. In May 1987, claimant again sought treatment from Dr. Damond.

The claim was closed by Determination Order on July 7, 1987. The Determination Order awarded claimant temporary partial disability from March 13, 1987 through April 9, 1987. There was no award of permanent partial disability.

CONCLUSIONS OF LAW

The Referee found that claimant was medically stationary on April 9, 1987 based on the fact that claimant was released to regular work as of that date. We disagree.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that his claim was prematurely closed. Austin v. SAIF, 48 Or App 7 (1980). In determining whether a claim has been properly closed, a determination of whether a claimant was medically stationary on the date of closure must be made, without considering subsequent changes in his or her condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, medical reports authored after closure may be considered where there has been no post-closure change in claimant's condition and the only question is whether claimant was stationary at the time of closure. Wojick v. Weyerhaeuser Co., 89 Or App 561 (1987); Scheuning v. J.R. Simplot Co., 84 Or App 622 (1987).

Here, we are not persuaded that claimant was medically stationary on April 9, 1987, the date he was given a full release to work by Dr. Herscher, or on July 7, 1987, the date of claim closure. In August 1987, Dr. Damond reported that claimant was not medically stationary and had not fully recovered from the injury

due to inadequate physical therapy. In September 1987, he reported that claimant was still symptomatic, but that he should improve with therapy and the passage of time.

In April 1987, Dr. Herscher did release claimant for regular work, but noted that claimant remained symptomatic in the upper back. Dr. Herscher does not offer an opinion as to whether or not claimant's condition was stationary.

The only evidence as to claimant's status comes from Dr. Damond. He treated claimant originally and again in May 1987. He opined that claimant was not medically stationary on July 13, 1987. As there is no contrary opinion, we conclude that claimant has established that he was not medically stationary at the time of claim closure. In reaching this conclusion we note that "medically stationary" is defined in ORS 656.005(17). That provision contains no reference regarding whether or not claimant was released to regular work. Accordingly, whether or not claimant was released for regular work has no bearing on the issue of medically stationary date. See William N. Suydam, 41 Van Natta 95, 96 (1989).

ORDER

The Referee's order dated December 16, 1987 is reversed in part and affirmed in part. That portion which affirmed the Determination Order is reversed. The Determination Order is set aside as premature and the claim is remanded to the employer for processing according to law. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,000. A client-paid fee, not to exceed $995, is approved.

KARL G. ROHDE, Claimant
Doblie & Associates, Claimant's Attorneys
Beers, et al., Defense Attorneys
Stafford Hazelett, Defense Attorney

WCB 87-13123, 87-05999 & 87-00973
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests, and EBI Companies cross-requests, review of Referee Neal's order which: (1) set aside its denials of claimant's aggravation claim for a low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for the same condition. On review, the sole issue is responsiblity. We reverse.

FINDINGS OF FACT

We adopt the findings of fact as set forth on pages one through four of the Referee's order.

FINDINGS OF ULTIMATE FACT

EBI submitted claimant's accepted low back injury claims to the Evaluation Division for closure prior to the issuance of its denial of claimant's aggravation claim for his current low back condition.

The incident of September 22, 1986, while Liberty Northwest was on the risk, independently contributed to a worsening of claimant's underlying low back condition.

CONCLUSIONS OF LAW

The Referee concluded that the incident of September 22, 1986 had independently contributed to claimant's low back condition. She found, however, that, as a matter of law, responsibility remained with EBI because its responsibility denial had been issued prior to closing claimant's claims. In making this ruling, the Referee relied upon Roller v. Weyerhaueser Co., 67 Or App 583 amplified, 68 Or App 743 rev den 297 Or 601 (1984), Webb v. SAIF, 83 Or App 386 (1987) and Arthur E. Matthews, 39 Van Natta 361 (1987).

We agree with the Referee's conclusion that the September 22, 1986 incident, while Liberty Northwest was on the risk, independently contributed to a worsening of claimant's underlying low back condition and adopt her reasoning on that point. We disagree, however, that EBI is responsible for that condition on the basis that its denial was issued prior to claim closure.

Subsequent to the hearing, the Court of Appeals decision in Chaffee v. Nolt, 94 Or App 83 (1988) was issued. In Chaffee, the insurer closed claimant's claim three days after issuance of a denial. Id at 85. The court noted that preclosure denials were generally improper in that they allowed insurers to circumvent their processing duties. Id. The court held, however, that the insurer's conduct in that case did not appear to be intended to shortcut the ordinary process of claim closure and, therefore, the preclosure denial was not improper. Id at 85-86.

We further note that we have previously permitted preclosure denials which have arisen in a responsibility dispute context. In Jimmy C. Lay, 37 Van Natta 583 (1985), the claimant sustained further injury while a prior injury claim was in an open status. The subsequent insurer contended that the prior insurer's preclosure denial was invalid for the reasons set forth in Roller, supra, and Safstrom v. Reidel International, Inc., 65 Or App 728 (1983). We disagreed, stating as follows:

> "We believe that it is the better policy to allow an employer/insurer to issue a preclosing denial of continued responsibility for an accepted condition where it appears that injuries or conditions, attributable to a subsequent employment, aggravate or exacerbate the condition such as to make a shift of employer/insurer responsibility appropriate. The practical effect of precluding responsibility denial in such a circumstance would be to make the first employer/insurer responsible for any and all effects of subsequent employments on the accepted condition between the time the claim is accepted and the time it is finally closed. We do not believe that such a result was intended."

37 Van Natta at 584. See also David D. Isaac, 38 Van Natta 997 (1986); Mason L. Asbury, 38 Van Natta 961 (1986).

Similarly, in the present case, EBI had submitted claimant's claim to the Evaluation Division prior to issuing its denial. Further, the issue, in the present case, was that of responsibility. In light of this, we conclude that EBI's action was not intended to bypass the claim closure process, nor did it have such an effect. Therefore, under the rationale expressed in Chaffee, supra and Lay, supra, we do not find that EBI was precluded from issuing an aggravation denial of claimant's current condition.

Inasmuch as we find that EBI was not precluded from issuing its denial, we conclude that the record establishes that Liberty Northwest is responsible for claimant's current condition. See Mission Insurance Co. v. Dundon, 86 Or App 470 (1987).

ORDER

The Referee's order, dated October 6, 1987, is reversed. Liberty Northwest Insurance Company's denial is set aside and the claim is remanded to it for processing according to law. EBI Companies' denial is reinstated and upheld.

GEORGE B. ROSSMAN, Claimant
Duncan & Lusk, Claimant's Attorneys
Meyers & Radler, Defense Attorneys

WCB 88-04231
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Garaventa's order that: (1) declined to award temporary total disability benefits beginning October 6, 1987; and (2) declined to assess a penalty or attorney fee for the self-insured employer's alleged unreasonable resistance to the payment of compensation. On review, the issues are temporary disability compensation and penalties and attorney fees.

The Board reverses in part and affirms in part the order of the Referee.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

The prior Referee set aside the employer's aggravation denial and directed it to process claimant's aggravation claim according to law. Neither party appealed the prior Referee's order. The employer declined to properly process the claim or to investigate the period(s) of claimant's entitlement, if any, to temporary disability compensation. As a result, the employer unreasonably resisted both the processing of the claim and the payment of compensation.

CONCLUSIONS OF LAW

The Referee found that the prior Referee's order did not require the payment of temporary disability compensation, save for a brief period in December, 1987, when claimant underwent "cybex testing." We disagree.

In the order portion of his order, the prior Referee stated:

> "1. Defendant's denial * * * is set aside. Claimant's aggravation claim is remanded to defendant for processing under the Worker's Compensation Law."

The Board faced a nearly identical factual situation in the case of Frank R. Gonzales, 34 Van Natta 551 (1982). In Gonzales, a prior Referee set aside the employer's aggravation denial; the Referee stated in the order portion of his order:

> "[T]he claim [is] remanded to the defendant for acceptance of an aggravation or worsening of claimant's back condition[,] which is related to his original accepted injury of July 26, 1974."

The prior Referee in Gonzales did not expressly order the payment of temporary disability compensation. The employer refused to pay any temporary disability compensation following the issuance of the prior Referee's order. Consequently, as here, the claimant requested a hearing to compel the payment of temporary disability compensation.

Holding that claimant was entitled to temporary disability compensation pursuant to the prior Referee's order, the Board stated:

> "[O]ne thing is crystal clear from [the prior Referee's] order: [C]laimant's aggravation claim was 'remanded to the defendant for acceptance.' Such wording imposes upon an insurer or self-insured employer the same duties it would have upon voluntary claim acceptance - to process the claim. In other words, if there were at the time of [the prior Referee's] order gaps or uncertainties about the duration of claimant's entitlement to time loss compensation, it was primarily the duty of the self-insured employer to investigate the matter, ascertain and then pay time loss appropriate under the circumstances.
>
> "Instead, the self-insured employer did nothing, taking the position that [the prior Referee] has ordered payment of medical benefits only. Even if [the prior Referee's] order was not a model of clarity, we find the self-insured employer's interpretation of it to have been farfetched and unreasonable." 34 Van Natta at 553. (Emphasis in original).

Here, as in Gonzales, the employer argues that the prior Referee's order made no express mention of an obligation to begin paying temporary disability compensation. As in Gonzales, we are not persuaded by the employer's argument. After the prior Referee

remanded claimant's aggravation claim to the employer for acceptance and processing "under * * * the law[,]" the employer had a duty to investigate and process the claim. ORS 656.262(1); Gonzales, supra. It did not do so. Accordingly, we conclude that the employer did not comply with the prior Referee's order.

Turning to the assessment of penalties and attorney fees, as in Gonzales, we find that the employer's refusal to process the claim amounted to an unreasonable resistance to the payment of compensation. See ORS 656.262(10) & 656.382(1). The only excuse offered by the employer is that the prior Referee's order created no duty to investigate any matter concerning claimant's entitlement to temporary disability compensation. As in Gonzales, we disagree and affirm the Referee's assessment of penalties and attorney fees.

ORDER

The Referee's order dated May 5, 1988, as reconsidered on May 31, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that declined to award temporary disability compensation beyond the period of time that claimant underwent cybex testing, is reversed. The employer is ordered to ascertain the period(s) in which claimant is entitled to temporary disability compensation according to law, see ORS 656.210, 656.262, 656.268 and 656.273, for the accepted aggravation claim that the prior Referee ordered it to process and to pay said compensation to claimant. In addition, the employer is ordered to pay claimant a penalty, payable in addition to his compensation, equal to 25 percent of the temporary disability compensation awarded by this order. Claimant's attorney is awarded a $500 penalty-related attorney fee, to be paid by the employer. That portion of the order that awarded temporary disability compensation for the period of time that claimant underwent cybex testing is affirmed.

Claimant's attorney is awarded an approved attorney fee equal to 25 percent of the increased temporary disability compensation awarded by this order, not to exceed $3,800. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $1,808.50.

NORA WILLIAMS, Claimant
Haugh & Foote, Claimant's Attorneys
Davis, et al., Defense Attorneys

WCB 87-16191
October 25, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Galloway's order that affirmed a Determination Order, which granted no award of permanent partial disability for her left wrist. In its respondent's brief, the insurer contends that the Referee erred in affirming the Determination Order award of temporary disability through September 3, 1987, and in rejecting its request for authorization for an offset of overpaid temporary disability compensation paid beyond August 14, 1987. The issues are temporary and permanent disability and offset. We reverse.

FINDINGS OF FACT

In April 1987, claimant filed a claim for tendinitis of the left wrist. Prior to that time, she had experienced

persistent pain in the left wrist. The claim was accepted by the insurer. In September 1987, the claim was closed by Determination Order, which awarded temporary disability benefits only through September 3, 1987.

Claimant's left wrist condition is chronic. She occasionally drops things due to pain and cannot lift over five pounds with the left wrist. Her left wrist remains painful when she is not using it, but not to as great an extent as when she is using it. When she uses the left wrist for any length of time, it becomes very painful. As a result of her compensable left wrist injury, she has sustained a loss of use or function in the minimal range.

FINDINGS OF ULTIMATE FACT

As a result of her compensable left wrist condition, claimant has sustained a loss of use or function of the left wrist equal to five percent.

Claimant was medically stationary on August 14, 1987. The insurer paid temporary disability benefits beyond that date.

CONCLUSIONS OF LAW

The Referee concluded that claimant had not established any permanent disability to her left wrist as a result of her compensable condition. We disagree.

Extent of scheduled permanent disability is measured by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining loss of use or function, we consider medical and lay evidence in light of the rules set forth in OAR 436-30-001 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. SAIF v. Baer, 61 Or App 335, 337-38, rev den 294 Or 749 (1983). Loss of use or function does not necessarily correlate with the mechanical impairment, although mechanical impairment is usually an important consideration. Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980). Claimant's testimony as to loss of use or function of a scheduled member can be a sufficient basis for an award of permanent disability. See Garbutt v. SAIF, 297 Or 148, 151 (1984).

Dr. Rabie reported that claimant's left wrist condition is chronic. Further, she cannot perform repetitive functions with her left hand. Claimant credibly testified that she cannot lift items over five pounds and occasionally drops things. She also testified that she experiences pain in the left wrist when she has to use it, as well as some pain when not using the left wrist.

After considering the aforementioned guidelines, and taking into account the medical evidence as well as claimant's credible testimony concerning her disabling pain and physical limitations, we conclude that a 5 percent scheduled permanent partial disability award for loss of use or function of the left wrist accurately reflects claimant's scheduled loss.

We turn to the temporary disability issue. The Referee affirmed the Determination Order, which found that claimant was entitled to temporary disability through September 3, 1987. The insurer contends that claimant's condition became medically stationary on August 14, 1987. We agree.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

Here, Dr. Nye, surgeon, performed an independent medical examination on August 14, 1987. In conjunction with this examination, electrodiagnostic studies were conducted, which were found to be normal. Dr. Nye considered claimant's condition to be medically stationary. Dr. Rabie, claimant's treating physician, agreed with Dr. Nye's examination.

Inasmuch as the medical evidence is in agreement that claimant's condition became medically stationary on August 14, 1987, we modify that portion of the Determination Order that awarded temporary disability benefits through September 3, 1987.

Regarding the offset issue, the Referee concluded that the insurer had failed to prove entitlement to an offset because it had failed to present evidence of the specific dollar amount of temporary disability compensation it overpaid. The insurer argues that the precise dollar amount of its offset is a claims processing matter which need not be proven in this proceeding, and that an offset may be authorized based upon a determination of the dates during which claimant was entitled to temporary disability compensation.

We agree with the insurer. No statute or rule requires proof of the specific dollar amount of an offset before it can be authorized. The Evaluation Section routinely authorizes offsets based upon its determination of the dates during which the claimant was entitled to temporary disability compensation; it allows the insurer to determine the precise dollar amount of the offset as a claims processing matter. See OAR 436-60-170(2). We have authorized offsets on the same basis. E.g., Michael T. Alioth, 41 Van Natta 386, 389 (1989); James D. Shirk, 41 Van Natta 90, 95 (1989). We adhere to that procedure in this case. Should the insurer ever have occasion to take the offset, of course, claimant retains the right to contest the dollar amount set by the insurer by way of a request for hearing under ORS 656.283.

ORDER

The Referee's order dated April 21, 1988 is reversed. Claimant is awarded 5 percent (7.5 degrees) scheduled permanent partial disability for loss of use of function of the left wrist. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,000. The Determination Order is further modified to award temporary disability through August 14, 1987, rather than September 3, 1987. The insurer is authorized to recover temporary disability compensation paid beyond August 14, 1987 against the current and, if an overpayment continues to exist, future awards of permanent partial disability granted on this claim. A client-paid fee, not to exceed $278.50, is approved.

LORNA G. BAKER, Claimant
Merrill Schneider, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-13894
October 26, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee St. Martin's order that: (1) held that her treating physician's letter of June 20, 1986 to the insurer was not an aggravation claim; and (2) upheld the insurer's "de facto" denial of her medical services claim for chiropractic care after June 30, 1987. We reverse.

ISSUES

1. Whether the treating physician's letter of June 20, 1986 was an aggravation claim.
2. If so, whether that claim was compensable.
3. Whether chiropractic treatment after June 30, 1987 was compensable.

FINDINGS OF FACT

Claimant sustained a compensable thoracocervical strain on October 3, 1980. The insurer accepted the claim for a disabling injury. Claimant treated conservatively with Dr. Wegner, a chiropractor, and returned to work for the employer. However, continuing symptoms forced her to quit that job, and she began working as a full-time waitress for another employer.

The claim was closed by Determination Order on August 17, 1982, with no permanent disability award. Claimant continued to receive palliative care from Wegner for periodic, symptomatic exacerbations along the cervical and thoracic spine. The frequency of treatment ranged from two to four visits per month.

Claimant quit her waitress job and, in October, 1985, she began working for the Portland Public Schools as a part-time helper in a bakery. She assumed full-time duties in February, 1986. On March 7, 1986, she experienced a flare-up of pain in the neck and middle back while lifting dough at work. The diagnosis was a mid-thoracic strain with associated thoracocervical and lumbar joint dysfunctions. She began treating three times weekly with Wegner and was totally disabled for more than 14 consecutive days before returning to modified work in late May, 1986. Claimant filed a "new injury" claim with the Portland Public Schools, but they denied responsibility for the claim on June 16, 1986. The denial was not appealed.

On June 20, 1986, Dr. Wegner wrote the insurer the following letter:

> "[Claimant] suffered an aggravation of her injury while she was working for the Portland Public Schools in the bakery on 3-7-86. Originally, a claim was filed with her employer, however, they denied it stating that it was as a result of her

original injury. Therefore, we are submitting the bills to you.

Enclosed are copies of the correspondence. We await your answer concerning this matter."

By letter of July 3, 1986, the insurer responded that it would accept claimant's "ongoing treatment." By that time, the frequency of treatment had been reduced to twice per week. Claimant eventually quit the bakery job due to lifting restrictions and began working as a companion for elderly individuals.

On June 30, 1987, the insurer denied claimant's "current chiropractic treatment" on the basis that the original 1980 injury had resolved and that continued treatment was not reasonable and necessary. Thereafter, medical bills for further chiropractic care were submitted to the insurer, and have not been paid.

FINDINGS OF ULTIMATE FACT

Dr. Wegner's letter of June 20, 1986 put the insurer on notice that claimant sought treatment for a worsened condition related to the compensable injury. The compensable injury materially contributed to both claimant's worsened condition in March, 1986, and her need for chiropractic treatment after June 30, 1987.

CONCLUSIONS OF LAW AND OPINION

The Referee held that Dr. Wegner's letter of June 20, 1986, was not an aggravation claim and upheld the insurer's "de facto" denial of chiropractic treatment rendered after June 30, 1987. We disagree with the Referee's decision on both issues.

Aggravation

1. Claim for Aggravation

A legally cognizable claim for aggravation must put the insurer on notice that claimant seeks treatment for a worsened condition. ORS 656.273(1), (3); Avalos v. Bowyer, 89 Or App 546, 549 (1988); Krajacic v. Blazing Orchards, 84 Or App 127, 130, on reconsideration 85 Or App 477, remanded for reconsideration on other grounds 304 Or 436 (1987). In holding that Wegner's letter was not an aggravation claim, the Referee reasoned that the letter merely requested medical services benefits under ORS 656.245 for continuing conditions resulting from the original injury. We disagree.

First, the letter specifically stated that claimant had suffered an "aggravation of her injury" on March 7, 1986. Because an aggravation is a worsening, the letter clearly indicated that the doctor felt a worsening had occurred. Additionally, the letter indicated that a claim was filed with the Portland Public Schools (PPS), the employer at the time of "aggravation," but that it was denied on the ground that the "aggravation" resulted from the original injury. The filing of the claim with PPS should have alerted the insurer that claimant was seeking benefits for more than continuing conditions. Finally, claimant's treatment frequency increased sharply after the "aggravation." Whereas she treated two to four times monthly prior to March, 1986, she was treating approximately 12 times monthly during the succeeding

months. When the language of Dr. Wegner's letter is viewed in the context of sharply increasing treatment frequency, we find that the insurer was put on notice that treatment for more than continuing conditions is indicated. The letter of June 20, 1986 was an aggravation claim. See Krajacic v. Blazing Orchards, supra.

2. Compensability of Claim

To establish a compensable aggravation claim, claimant must prove that: (1) her condition has worsened since the last award of compensation, so that she is more disabled; and (2) the worsened condition is causally related to the original compensable injury. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986).

To prove a worsening of her condition, claimant must prove that she is more disabled, meaning less able to work, than she was at the time of the last award or arrangement of compensation. Smith v. SAIF, supra. Here, the last award of compensation was the August 17, 1982, Determination Order that awarded no permanent disability. Hence, we infer that the award did not contemplate any future flareups resulting in total disability. Due to increased symptoms resulting from the March 7, 1986, incident, Dr. Wegner took claimant off work from March 11 to May 7, 1986. Claimant returned to modified work for a few days, but her symptoms again forced her to leave work from May 12 to May 27, 1986. We find, therefore, that claimant was at least temporarily more disabled than she was at the time of the last award of compensation. We are persuaded that claimant's condition had worsened since the last award of compensation. See id.

On the element of causation, claimant contends that the insurer, by specifically accepting "ongoing treatment" for increased symptoms on July 3, 1986, effectively conceded the causal connection between her current symptoms and the original compensable injury and cannot subsequently deny the same. We do not reach that question because we find, based on the medical evidence, that claimant's worsened condition was related to the compensable injury.

The medical evidence on causation is divided. Dr. Utterback, an orthopedist, conducted an independent medical examination for PPS on May 27, 1986. Utterback related current symptoms to the original thoracocervical injury in 1980, based on the six-year history of continuous chiropractic treatment and the similarity between past and present symptoms. Dr. Wegner concurred.

A contrary opinion was offered by Dr. Howell, an osteopath who conducted an IME for the insurer on June 5, 1987. Howell opined that the original 1980 injury had resolved, asserting that current complaints of increased symptoms in the mid-thoracic spine developed only after the March, 1986, incident and could not be related to the original injury.

We are more persuaded by the opinions of Drs. Wegner and Utterback. As treating physician, Wegner has had continuous, first-hand exposure to claimant's condition since the original injury in 1980; therefore, his opinion is entitled to greater weight. Weiland v. SAIF, 64 Or App 810, 814 (1983). Further, Utterback examined claimant some three months after her condition worsened, whereas Howell did not see claimant until more than one

year had passed. For that reason, Utterback had a better opportunity to evaluate claimant's condition. Finally, Utterback's opinion was supported by the record. For the six years following the original injury, claimant had been treating with Wegner for periodic exacerbations of symptoms along the thoracocervical spine. Claimant's past symptoms were similar to those she experienced after the March, 1986, incident. In November, 1985, Wegner treated her for pain in the cervical, upper thoracic and lower thoracic spine, and diagnosed chronic thoracocervical strain. After the 1986 incident, claimant had pain and myospasms in the cervical spine and throughout the thoracic spine. Although the symptoms involved a greater portion of the spine, they were located roughly in the same areas previously injured. For the forgoing reasons, we are satisfied that claimant's worsened condition was causally related to the original compensable injury. Claimant's aggravation claim is compensable.

Compensability of Medical Services

On review, claimant does not challenge the insurer's June 30, 1987 denial of "current chiropractic treatment." Rather, she challenges the insurer's "de facto" denial of chiropractic treatment rendered after the date of denial. The insurer responds that post-denial treatment was for the same condition for which treatment was originally denied and, for that reason, litigation of the compensability of post-denial treatment is precluded, apparently on the basis of res judicata. We disagree.

We have held that the res judicata effect of an unchallenged denial of medical services is limited to medical services rendered on or before the date of the denial. David E. Gates, 40 Van Natta 798, 800 (1988); Leonard A. Chambers, 40 Van Natta 969, 971 (1988). The doctrine of res judicata does not bar claimant from raising the issue of the compensability of post-denial treatment. Id. Therefore, we now consider the question of the compensability of post-denial treatment in this case.

To establish the compensability of post-denial chiropractic treatment, claimant must prove that her current condition and resulting need for treatment are materially related to her original injury. ORS 656.245(1); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Jordan v. SAIF, 86 Or App 29, 32 (1987). Claimant's symptoms have remained essentially the same in nature and location since her condition worsened in March, 1986. Moreover, she has consistently treated with Wegner for those symptoms since the worsening. Given the continuity of symptoms and treatment since the worsening, our disposition of the aggravation issue, particularly the causation element, effectively resolves this issue in favor of compensability. The compensable injury materially contributed to claimant's current condition and her need for treatment after June 30, 1987. Post-denial treatment is compensable.

ORDER

The Referee's order dated February 1, 1988, is reversed in part and affirmed in part. The insurer's "de facto" denial of claimant's aggravation claim is set aside and the claim is remanded to the insurer for processing according to law. The insurer's "de facto" denial of medical services rendered after June 30, 1987,

is set aside, and the insurer is ordered to pay all bills received for medical services rendered after that date unless denied within the time provided by law. The remainder of the Referee's order is affirmed. For services rendered at hearing and on review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the insurer. The Board approves a client-paid fee not to exceed $1,064.

MICHAEL C. BATORI, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0288M
October 26, 1989
Own Motion Order Reviewing Self-Closure

Claimant requests review of the SAIF Corporation's July 3, 1989 Notice of Closure of this own motion claim. That notice found claimant medically stationary as of June 9, 1989, and awarded temporary disability benefits from April 4, 1989 through April 20, 1989. Claimant contends that his claim was prematurely closed, and that he is entitled to further temporary disability compensation.

This claim was initially reopened by Board Own Motion Order, issued May 31, 1989. Under that order, claimant is entitled to temporary disability compensation until he becomes medically stationary or returns to regular work at the regular wage. SAIF's Notice of Closure was premature if it was issued before claimant became medically stationary. ORS 656.278(1)(a).

In issuing its Notice of Closure, SAIF relied on a standard supplemental medical report form, completed by treating physician Hirshman on June 12, 1989. Dr. Hirshman checked boxes on that form indicating that claimant was released to regular work on April 21, 1989, and currently medically stationary.

However, it appears that, prior to closure, Dr. Hirshman changed his opinion. In a July 2, 1989 letter to SAIF, Dr. Hirshman noted that claimant has not been able to return to his regular work since his knee surgery in April 1986. Dr. Hirshman also noted the possibility that claimant would need more major reconstructive surgery, and he stated that he had advised claimant to return for further treatment in August 1989 if he had not improved sufficiently to return to work. Several days later, on July 10, 1989, Dr. Hirshman completed a release to modified work form clearly stating that claimant was not medically stationary.

Based on this medical evidence, we are persuaded that claimant did not return to his regular work after he was released to work in April 1989. We are further persuaded that claimant was not medically stationary when SAIF issued its Notice of Closure on July 3, 1989. Accordingly, we conclude that the insurer's Notice of Closure was improper, and that SAIF improperly terminated claimant's temporary disability benefits on April 20, 1989.

We, therefore, set aside the Notice of Closure and instruct SAIF to recommence payment of temporary disability benefits as of April 21, 1989. SAIF should continue paying temporary disability compensation until claimant is medically stationary or returns to his regular work at the regular wage, whichever is earlier. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055. 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.

LEO A. DEG, Claimant
Royce, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 87-03339
October 26, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Neal's order which: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent partial disability for a neck injury from 60 percent (192 degrees), as awarded by a prior Determination Order and Referee's order, to 80 percent (256 degrees); and (3) increased claimant's scheduled permanent partial disability award for loss of use or function of the right arm from 15 percent (28.8 degrees), as awarded by a prior Determination Order and Referee's order, to 65 percent (124.8 degrees). On review, claimant contends that he is permanently totally disabled. We agree and reverse.

FINDINGS OF FACT

In January 1982, claimant sustained a compensable injury to his neck and right shoulder. A subsequent myelogram revealed a herniated disc, right side C6-7. In November 1982 claimant underwent a laminectomy. The claim was closed by a March 1984 Determination Order that granted claimant 20 percent unscheduled permanent disability for his neck injury and 15 percent scheduled permanent disability for loss of use or function of his right arm.

Claimant appealed the Determination Order and a prior Referee granted claimant an additional 40 percent unscheduled permanent disability. At that time, neurological testing revealed that he had irreversible nerve changes and loss of muscle in the right arm. In May 1984, a psychological screening indicated poor reading skills, with claimant's vocabulary at the 4th grade level and comprehension at the 5th grade level. In July 1984, claimant was terminated by the employer because it did not have work for him within his medical limitations.

In October 1984, claimant was approved for an authorized training program. An evaluation at that time showed that claimant functioned in the dull normal range in verbal and non-verbal testing. In March 1985, claimant's vocational service provider changed. In April 1985, Dr. Chandler reported that claimant was incapacitated from regular work. Claimant's new vocational counselor sent claimant for an employment training program evaluation in June 1985. Claimant was found eligible, but medical problems and some confusion regarding his limitations caused a delay in entering the program.

In July 1985, claimant was diagnosed as having right carpal tunnel syndrome. The employer denied this condition and a disputed claim settlement disposed of the carpal tunnel syndrome claim. During this time, vocational services were delayed while claimant's physical problems were being clarified. In January 1986, claimant's vocational provider was again changed, this time

at claimant's request. Vocational consultant Alverson began working with claimant in February 1986.

In March 1986, claimant developed a frozen shoulder syndrome as a result of his injuries and surgery. In May 1986, Alverson and claimant developed an approved training program to retrain claimant as a motel or restaurant manager. Dr. Chandler, claimant's then treating physician, approved this vocational goal. As part of his training, claimant began receiving adult basic education and tutoring at a community college.

In mid-May 1986, claimant suffered an exacerbation of neck and right shoulder pain from using the computer at his training school. He missed some time from school and had difficulty tolerating the work for more than a brief period of time because of pain. He worked hard and made adequate academic progress but was only able to tolerate 1 1/2 to 3 hours of school a day, and that with considerable difficulty. Claimant achieved only 25 to 30 percent of the level that was needed for entry level sedentary work.

Claimant's training and vocational assistance was terminated in August 1986 for medical reasons and because it had been determined that his training would not prepare him for work he would be able to do.

Claimant is 49 years old with an 8th grade education. He obtained a GED in 1963 or 1964. He had worked for the employer for over 23 years on the pot lines. His only other job was several years' work in a foundry.

Claimant can occasionally lift, carry, push, and pull up to 20 pounds. He can occasionally bend, twist, crouch and kneel. Claimant can frequently walk on even or uneven surfaces and climb stairs.

FINDINGS OF ULTIMATE FACT

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation as a result of his compensable injury. Claimant has made reasonable efforts to find work.

CONCLUSIONS OF LAW

The Referee found that claimant was not permanently totally disabled. We disagree.

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as conditions of the labor market. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his nonmedical

disabilities renders work search futile, he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594 (1988).

As a result of his compensable injury and subsequent laminectomy, claimant has significant physical disability. He has continuous right neck and shoulder pain. He has lost a significant amount of function in the right upper extremity, and the shoulder is "frozen." He also has deterioration of the disks in the cervical spine. Despite these limitations, claimant's physicians have opined that he is capable of light or sedentary work. Therefore, in order to establish permanent total disability, claimant's physical limitations combined with the relevant nonmedical factors, must render him incapable of regularly performing gainful, suitable work.

Claimant is 49 years old. He has a formal education through the 8th grade, but did obtain a GED in 1963 or 1964. He has worked for the employer on the pot lines for 23 years. His only other work experience was several years work in a foundry. Testing done in 1984 indicated claimant's reading skills were poor with his vocabulary at the 4th grade level and his comprehension at the 5th grade level. Further testing indicated that claimant functioned in the dull normal range in verbal and non verbal testing. Claimant did participate in trying to upgrade his English and math skills at a community college; however, his physical difficulties forced him to terminate his participation after achieving only 25 to 30 percent of the level that was needed for entry level sedentary work.

Vocational counselor Alverson originally indicated that claimant would not be employable without retraining. He found no transferable skills other than common sense and life experience. Nonetheless, he testified that claimant could perform work as a security guard.

By contrast, vocational expert Goodwin testified that claimant had no transferable skills and, given his low intellectual abilities and slow ability to learn and adapt to new work, he concluded that claimant was unemployable. Goodwin further concluded that claimant could not work as a security guard as he had conducted an informal market survey in the Dalles area and found no one who would be willing to hire claimant.

We conclude that claimant has established permanent total disability. Claimant's physical limitations combined with his limited work experience and low intellectual abilities have precluded him from regularly performing work at a gainful, suitable occupation. We are not persuaded by Alverson's conclusory opinion that claimant could perform security guard work, particularly in light of his earlier opinion that claimant was unemployable without retraining. Further, we find that claimant has actively participated in rehabilitation efforts and was forced to terminate such efforts because of his compensable condition. Therefore, any further efforts would be futile. See Butcher v. SAIF, 45 Or App 318 (1983).

ORDER

The Referee's order dated November 10, 1987 is reversed. Claimant is granted permanent total disability as of October 29, 1987. The self-insured employer is authorized to offset the permanent partial disability benefits paid pursuant to the Referee's order against the permanent total disability award. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, but total fees awarded by the Referees and the Board shall not exceed $6,000. A client-paid fee, not to exceed $1,206, is approved.

RICHARD FITTING, Claimant	WCB 83-08553
Black, et al., Claimant's Attorneys	October 26, 1989
Cowling & Heysell, Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Mongrain's order which: (1) increased claimant's unscheduled permanent disability for a low back injury from 55 percent (176 degrees), as awarded by Determination Order, to 100 percent (320 degrees); and (2) declined to grant permanent total disability benefits. We affirm.

ISSUES

1. Whether the Board has jurisdiction to consider claimant's request for review.

2. Whether claimant is entitled to permanent total disability benefits.

FINDINGS OF FACT

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

Claimant last worked in March of 1985 and, except for two weeks prior to the January 16, 1987 hearing, had not searched for any kind of job.

During the two weeks prior to the January, 1987 hearing claimant, at the direction of his attorney, made a cursory attempt to seek employment. The jobs, in a furniture store and grocery store, were not of the type claimant was capable of doing.

Claimant is not permanently incapacitated from performing work at a gainful and suitable occupation. It would not be futile for him to seek work. Claimant is not willing to seek regular, gainful employment, nor has he made reasonable efforts to obtain employment.

The Referee's order issued August 26, 1987.

Claimant requested Board review of the Referee's order on September 4, 1987. Copies of the request were sent to the attorneys for the employer and its claims administrator. On September 17, 1987, the Board mailed a computer generated acknowledgment of the request to all of the parties.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction of the Board

The employer has moved for an order dismissing the appeal, claiming that the request for Board review filed by claimant's attorney was defective in its service because claimant did not notify all parties when filing his request. See ORS 656.289(3); 656.295(2). Claimant served notice on the attorney for the employer and its claims administrator. However, no notice was served on the employer or its claims administrator.

Respondent makes no assertion that the employer or its claims administrator has been prejudiced by the lack of personal notice of the request for review. In the absence of such prejudice, timely service on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Robert C. Jaques, 39 Van Natta 299 (1987); Argonaut Insurance v. King, 63 Or App 847, 852 (1983). Furthermore, because the Board's acknowledgment letter was mailed to the parties 22 days after the Referee's order, we conclude that it is more probable than not that the employer received actual notice of claimant's request for review within the statutory 30-day period. See John D. Francisco, 39 Van Natta 332 (1987). Accordingly, the motion to dismiss is denied.

Permanent Total Disability

Concluding that claimant had not demonstrated motivation to seek work or participate in vocational rehabilitation, the Referee declined to grant permanent total disability benefits. Instead, he increased claimant's unscheduled permanent disability award from 55 percent to 100 percent. We agree.

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market". Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders work search futile, SAIF v. Scholl, 92 Or App 594 (1988), he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

A claimant's attitude toward returning to work may be relevant in determining whether the claimant "is excluded from employment by his or her own will rather than by that of employers." Wilson, supra, 30 Or App at 412.

The Referee believed that claimant was not "incapable of making a conscious choice to provide or withhold his best effort" while in physical and vocational rehabilitation, or while seeking employment. Claimant declined to participate in pain center rehabilitation, claiming that it was his treating doctor's opinion that he not participate. On the contrary, his treating doctor believed that it would be in claimant's best interest to attend

the pain center, but stated that claimant's attitude and lack of motivation prevented the doctor's insistence on attendance at that particular time.

Claimant excelled in courses in a bookkeeping program in which he was enrolled, but did not continue the program even though he was afforded the opportunity to use modified furniture while in class. Two weeks before his hearing, claimant made an abbreviated effort to seek work at jobs he did not feel capable of performing.

The Referee found that, of the two vocational experts whose testimony was considered, Mr. Alverson was the most persuasive. Alverson stated that claimant lacks the motivation to be rehabilitated, but does possess adequate skills for some types of gainful employment such as security guard, bookkeeper, or motel/apartment manager. We concur with the Referee's assessment of this medical and vocational evidence. Consequently, we conclude that claimant was not permanently incapacitated from performing work at a gainful and suitable occupation.

Alternatively, we also agree that, because of lack of motivation, claimant was unwilling to seek regular gainful employment or make reasonable efforts to obtain rehabilitation to facilitate his return to such employment.

We turn to the issue of permanent partial disability.

In rating the extent of claimant's unscheduled permanent disability, we consider his loss of earning capacity and physical impairment attributable to the compensable injury, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our de novo review of the medical and lay evidence, and considering claimant's relatively severe physical impairment and the relevant social and vocational factors, we agree that an award of 100 percent unscheduled permanent disability appropriately compensates claimant for his compensable low back injury.

ORDER

The Referee's order, dated August 26, 1987, is affirmed. A client-paid fee, payable from the self-insured employer to its counsel is approved, not to exceed $789.00.

JERRY L. MILLER, Claimant	WCB 88-00291
Pozzi, et al., Claimant's Attorneys	October 26, 1989
Rankin, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Galton's order which upheld the insurer's denial of his aggravation claim for a bilateral shoulder injury. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable bilateral shoulder injury in January 1987. He returned to modified employment in June 1987. Claimant continued to work until November 25, 1987, when he had a noninjury-related seizure. On or about that day, claimant by himself lifted and hung a door at work, from which increased symptoms resulted. Claimant returned to work following the incident and was ultimately laid off on December 11, 1987 for reasons unrelated to his injury.

A December 7, 1987 Determination Order closed claimant's claim awarding 15 percent unscheduled permanent disability as well as temporary disability benefits through September 9, 1987.

On January 12, 1988, Dr. Stellflug released claimant from work. In March 1988, the insurer denied claimant's aggravation claim for his low back injury.

Claimant's low back condition symptomatically worsened in November 1987. His low back condition has not worsened since the December 1987 Determination Order (i.e, the last arrangement of compensation).

CONCLUSIONS OF LAW

The Referee found that claimant had not established that his condition had worsened beyond a "waxing and waning" anticipated by the last arrangement of compensation. Although we agree with the result, we modify his reasoning.

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the compensable injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening, claimant must show that he is more disabled, i.e. less able to work, since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986).

Here, claimant's last arrangement of compensation was the December 7, 1987 Determination Order. Prior to that order, on November 25, 1987, Dr. Stellflug opined that claimant's condition had worsened due to the door hanging incident. He testified that claimant's condition remained the same on December 11, 1987, and on January 12, 1987, the latter being the date he released claimant from work.

The medical evidence, therefore, indicates that claimant's condition subsequent to the Determination Order was the same as in November 1987, prior to the Determination Order. Thus, claimant has failed to establish that his condition worsened since the last arrangement of compensation. Inasmuch as a worsened condition since the last arrangement of compensation is a prima facie element of an aggravation claim, ORS 656.273(1), claimant has not proven an aggravation. Accordingly, the insurer's aggravation denial must be upheld.

ORDER

The Referee's order dated May 9, 1988 is affirmed. A client-paid fee, not to exceed $1,113.50, is approved.

BRYAN D. WARRILOW, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-09029
October 26, 1989
Second Order on Remand

Claimant has requested reconsideration of our September 26, 1989 Order on Remand that reversed a Referee's order which had set aside the self-insured employer's partial denial of degenerative changes and osteophytic spurring in claimant's cervical spine. Objecting to our ultimate finding that claimant's compensable injury was not a material contributing cause of degenerative changes and osteophytic spurring of his cervical spine or its worsening, claimant seeks an order of clarification. Claimant also requests that this matter be remanded for consolidation with WCB Case No. 87-09098, a subsequent case which concerns related issues between these parties.

After further consideration, we conclude that the issue before us is whether the compensable injury is causally related to claimant's degenerative changes and osteophytic spurring, as denied by the employer on June 19, 1986. Thus, our previous ultimate finding of fact is replaced by the following ultimate finding of fact: "The compensable injury is not a material contributing cause of degenerative changes and osteophytic spurring of claimant's cervical spine, as shown on x-rays taken at Mt. Hood Medical Center on March 7, 1986."

Turning to the request for remand and consolidation, we are not persuaded that the record concerning the question of whether the compensable injury is causally related to the aforementioned degenerative changes has been improperly, incompletely or otherwise insufficiently developed. Other than bare assertions describing this post-hearing surgical evidence as "definitive", claimant has not presented copies of this evidence which he implicitly contends has rendered this record improperly, incompletely or otherwise insufficiently developed. Consequently, we conclude that remand is not appropriate. See ORS 656.295(5).

Accordingly, our September 26, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 26, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

HUGH L. ALLEN, Claimant
Malagon, et al., Claimant's Attorneys
Miller, et al., Defense Attorneys

WCB 85-08733
October 27, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Brown's order which: (1) found that claimant's low back claim was not prematurely closed; (2) found that claimant had not established good cause for his untimely hearing request concerning the self-insured employer's denial of psychiatric billings and treatment; and (3) upheld the employer's partial denial of claimant's irritable bowel condition, as well as a denial of claimant's aggravation claim for his low back condition. Claimant has submitted several supplemental documents, some of which were not submitted at the hearing. We treat these as a request for

remand. The issues on review are remand, premature closure, jurisdiction, aggravation, and compensability. We affirm the Referee's order.

FINDINGS OF FACT

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

Claimant has a history of numerous medical problems, including arthritis, hepatitis, nonfunctioning gall bladder and hemorrhoids. All of these problems are unrelated to claimant's compensable injury.

Claimant had been treating for low back pain during the year prior to his compensable injury, and had injured his back at home about two months before his compensable injury.

The record has not been incompletely, insufficiently, or inadequately developed.

CONCLUSIONS OF LAW AND OPINION

Claimant submitted several letters, affidavits and tape recordings to the Board after the record of his hearing was closed. These documents are treated as a request for remand. To merit remand for consideration of additional evidence, it must be clearly shown that the evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). Here, we find that the numerous exhibits already in the record were sufficient to completely, sufficiently, and adequately develop the record. See ORS 656.295(5). Thus, the motion to remand is denied.

Premature closure of claim

We affirm the Referee's findings and conclusions with the following comment.

Claimant contends that, because of certain statements made by the Referee during closing arguments, the Referee, at that time, had already decided that claimant's claim was prematurely closed. However, we note that the Referee specifically stated during that conversation that he had not yet decided the case. Thus, we disagree with claimant's argument that the Referee's order was contrary to his "original conclusion."

Timeliness of Hearing Request

On May 3, 1985, the employer denied claimant's request for payment of psychological treatments. Claimant did not request a hearing from that denial until more than one year later. The Referee stated that he could not find good cause for not filing the request timely.

Claimant argues that the Referee incorrectly viewed the standard for timeliness as "good cause" when he should have made a finding of claimant's mental competence. If claimant was found to be incompetent, he would not be held to the sixty-day period for requesting a hearing, but rather may be allowed up to five years. ORS 656.319(2). Claimant contends that the Board should remand

this case to the Referee for a determination of mental competency. We disagree.

The statute allows a five year extension of filing time if a person lacks mental competency. The lack of mental competency contemplates requiring commitment or voluntary admission to a treatment facility pursuant to ORS 426.005 to 426.380 and the rules of the Mental Health Division. On review, the record suggests that claimant experiences psychological problems. Yet, there is no indication that these problems required commitment or voluntary admission to a mental health treatment facility. Accordingly, we are unable to find that claimant lacked the mental capacity to timely request a hearing from the employer's denial. Furthermore, we do not find that the record has been incompletely, insufficiently or inadequately developed as to the question of mental competency. See ORS 656.295(5). Thus, claimant's motion for remand is denied.

Aggravation of low back condition

In order to establish an aggravation claim, claimant must show "worsened conditions resulting from the original injury." ORS 656.273. In addition, claimant must establish that, as a result of such worsening, he is more disabled, meaning less able to work, either temporarily or permanently, than he was at the time of the last award or arrangement of compensation. Smith v. SAIF, 302 Or 396, 399 (1986). "Worsened conditions" may take the form of either a worsening of the underlying condition or a symptomatic worsening. Smith, supra.

Dr. Dunn from the Pain Treatment Clinic stated that claimant had a worsening of his condition between the time of Dr. Thompsen's closing examination of January 29, 1985, and Dr. Dunn's first examination of June 6, 1985. The Referee was not persuaded by this conclusory opinion and found that claimant's condition had not worsened. We agree.

Several physicians, including the Diagnostic Panel (Ex. 80), and Drs. Hartmann (Ex. 72), Matthews (Ex. 80A), Klump (Ex. 81A), Campagna (Ex. 82,85) and Thompsen (Ex. 83), have stated and/or concurred that claimant's condition had not worsened since early 1985. Moreover, claimant acknowledges that his condition remained essentially the same during the time in question. Consequently, we agree with the Referee and conclude that claimant has not sustained his burden of proof in showing a worsening of his condition since January 29, 1985, the last award of compensation.

Compensability of irritable bowel syndrome

In reference to claimant's irritable bowel syndrome, the Referee found the opinion of "The Diagnostic Panel" to be more persuasive than the opinion of Dr. Seeley, who concluded, without any explanation, that the irritable bowel syndrome was "aggravated by his tension related to his Workmans [sic] Comp. hearing." After reviewing claimant's medical history and completing its own physical examination, the Diagnostic Panel did not relate claimant's irritable bowel syndrome to his compensable injury nor to the process of recovery from that injury. This opinion was

shared by several other examining physicians. We agree with the Referee that the aforementioned opinion is more persuasive than the conclusory opinion of Dr. Seeley. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

ORDER

The Referee's order dated August 21, 1987 is affirmed.

CARROL A. BELLE, Claimant
(Surviving spouse for deceased worker, C. Arthur Belle)
Douglas A. Hess, Claimant's Attorney
Acker, Underwood, et al., Defense Attorneys
David Horne, Defense Attorney

WCB 86-12257 & 85-15761
October 27, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

The deceased worker's surviving spouse request review of Referee Shebley's order that upheld: (1) Wausau Insurance Company's denial of decedent's 1985 heart attack claim; and (2) Liberty Northwest Insurance Corporation's denial of decedent's 1986 heart attack and death claim. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

Decedent was president of Crane Body and Equipment Company, which was owned jointly by himself and Mr. Hovis.

In April of 1985 decedent saw Dr. Mick, a family practitioner, with complaints of fatigue. Dr. Mick noted that decedent had a high cholesterol level and smoked 1-1/2 packs of cigarettes a day.

In May of 1985 the company was sued for breach of contract. This litigation resulted in a $175,000 judgment. Concerned about how this judgment was to be paid, and confronted with a deteriorating relationship with his partner, decedent experienced anxiety and depression.

On August 27, 1985 decedent returned home from work in an agitated state. He was further upset by a telephone call from an employee over a business related issue. Shortly thereafter, he attempted to stack some hay bales. While doing so, he collapsed.

Decedent's condition was diagnosed as an acute inferior myocardial infarction caused by the complete occlusion of decedent's right coronary artery.

On June 4, 1986, decedent had a second, this time fatal, myocardial infarction during an evening walk. An autopsy revealed that his right proximal coronary artery had totally occluded causing an acute myocardial infarction. It also revealed severe atherosclerosis of this artery, with minimal to moderate atherosclerosis of the left coronary artery.

Four physicians testified at hearing. Doctor Foresman, decedent's treating physician, a family practitioner, opined that decedent's job-related emotional stress was a very major contributing cause of decedent's myocardial infarctions. Dr. Foresman's opinion was buttressed by Dr. Smith, a

psychiatrist. Dr. Smith, based upon review of the medical record and interviews with decedent's family, opined a direct causal relationship between the stress and the myocardial infarctions.

Dr. Kloster, a consulting cardiologist, did not believe stress played a causal role in decedent's heart condition. It was his opinion that the myocardial infarctions were the result of the natural progression of decedent's preexisting atherosclerosis. Nor did Dr. Kloster opine stress as a causative worsening factor of the disease's progression. Rather, he believed that decedent's high cholesterol level and heavy smoking behavior were more significant. This opinion was based on verifiable medical studies concerning major risk factors in heart disease. Claimant's treating cardiologist, Dr. Reinhart concurred with this analysis.

ULTIMATE FINDINGS OF FACT

At the time of his first myocardial infarction, decedent was suffering from chronic emotional stress stemming from his troubled business. Immediately prior to the first myocardial infarction, he had an episode of acute emotional stress when he received a call from an employee which caused immediate upset.

Claimant's emotional stress did not materially contribute to the causation of his heart condition. Rather the myocardial infarctions were the result of the natural progression of his preexisting atherosclerosis disease.

CONCLUSIONS OF LAW

The Referee concluded that decedent's myocardial infarctions were not compensable because he found the medical opinions of Drs. Kloster and Reinhart more persuasive. The Referee noted that both doctors were specialists in this complex scientific field. We agree with the Referee's reasoning.

To establish a compensable heart condition, a claimant must prove that the work activity was both the legal and medical cause of the condition. Somers v. SAIF, 77 Or App 259, 262 (1986); Bush v. SAIF, 68 Or App 230, 232 (1984). Legal causation, in cases of emotional stress, can be established by a showing of chronic emotional stress or an episode of acute stress. Harris v. Farmers' Co-op Creamery, 53 Or App 618, rev den 291 Or 893 (1981). If analyzed as an industrial injury, the medical causation question is whether the stress was, within reasonable medical probability, a material contributing cause of the infarction. Coday v. Willamette Tug & Barge, 250 Or 39, 47 (1968). Adams v. Gilbert Tow Service, 69 Or App 318, 321 (1984). If analyzed as an occupational disease, the medical causation question is whether claimant's work conditions were the major contributing cause of his heart condition, or its worsening. Weller v. Union Carbide, 288 Or 27, 35 (1979); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Gygi, 55 Or App 570, 574, rev den 292 Or 825 (1982). Medical causation must be established by medical experts. Bush v. SAIF, supra.

Here, legal causation is not an issue. Claimant has established both chronic and acute emotional stress as work related.

The issue of medical causation is a closer question. 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, 77 Or App at 263.

Although Dr. Foresman persuasively testified as to the effect of decedent's business concerns resulting in chronic emotional stress, he failed to persuasively establish how this stress resulted in either a worsening of the underlying atherosclerosis disease or in precipitating the two myocardial infarctions. Nor did the supportive testimony of Dr. Smith, psychiatrist, provide the necessary causal connection. Both doctors admitted to their limited knowledge in the field of cardiology.

In contrast, Dr. Kloster persuasively explained how the immediate cause of the two myocardial infarctions was blood clots which developed as a reaction to fissures on the surface of the atheroma. These blood clots, in conjunction with the arterial narrowing caused by the preexisting atherosclerosis, constricted the arterial openings sufficiently so that critical occlusion of the arterial opening occurred. He further explained that the timing of the formation of the clots could not be determined as they were the result of the natural progression of the underlying disease and not the immediate result of any external factor. Finally, Dr. Kloster concluded that stress was of no significance in producing either a worsening of the disease or in triggering blood clots.

Although Dr. Kloster did not personally examine decedent, he did have access to all of decedent's medical files. Further, he is an expert in the field of cardiology, and his medical views of causation were concurred in by Dr. Reinhart, decedent's treating cardiologist. Dr. Kloster's medical opinion was well reasoned and based on complete information, and therefore, is given great weight. Accordingly, claimant has failed to prove the medical probability of decedent's work related emotional stress being a material contributing cause of decedent's myocardial infarctions. We are likewise unpersuaded that claimant's emotional stress was the major contributing cause of his heart condition or its worsening.

ORDER

The Referee's order dated November 27, 1987 is affirmed. The Board approves a client-paid fee, payable from the Liberty Northwest Insurance Corporation to its counsel, not to exceed $712.50.

YVONNE E. BENSON, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0734M
October 27, 1989
Own Motion Order Reviewing Self-Closure

This claim was initially reopened by Board Own Motion Order, issued December 13, 1988. Claimant now requests review of the SAIF Corporation's April 11, 1989 Notice of Closure of the claim. SAIF issued that closure under ORS 656.278. On review, claimant contends that she is entitled to closure under ORS 656.268. We agree.

This claim was reopened in 1983 and remained in open status when claimant's aggravation rights expired in January 1984. The claim was then reclosed by a March 7, 1986 Determination Order.

Another Determination Order issued on May 26, 1988 following claimant's participation in an Authorized Training Program. Claimant requested a hearing on both Determination Orders. (WCB 85-10239). That litigation was pending when the Board reopened the claim on December 13, 1988. Under these circumstances, claimant is entitled to reclosure of her claim under ORS 656.268. ORS 656.268(5); Buell v. S.I.A.C., 238 Or 492 (1964); Carter v. SAIF 52 OR App 1027 (1981); Wayne D. Cooper, 38 Van Natta 913 (1986); Jeffrey Barnett, 36 Van Natta 1636 (1984).

Accordingly, we grant claimant's request to set aside SAIF's April 11, 1989 Notice of Closure. The claim is remanded to SAIF for further processing according to law.

IT IS SO ORDERED.

ARLENE CONVERSE, Claimant — Own Motion 87-0764M
Pozzi, et al., Claimant's Attorneys — October 27, 1989
Industrial Indemnity, Insurance Carrer — Own Motion Order Reviewing Self-Closure

Claimant requests review of the insurer's April 5, 1989, Notice of Closure, which terminated temporary disability benefits as of March 29, 1989. Claimant contends that the closure of her claim is governed by pre-1988 "own motion" law and that, under that law, she is entitled to permanent total disability benefits. Alternatively, she opposes the termination of temporary disability benefits.

By Own Motion Order dated September 7, 1988, the Board reopened claimant's claim with temporary disability benefits commencing October 5, 1987, and continuing until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Because the Board ordered the claim reopened after January 1, 1988, this case is governed by current own motion law. See Or Laws 1987, ch 884, §§ 37, 62; OAR 438-05-010. Under current own motion law, the Board's authority to award further compensation on post-1965 claims is limited to temporary disability benefits. See ORS 656.278(1)(a). Hence, the Board lacks the authority to award claimant any additional permanent disability, including permanent total disability. See Orville D. Shipman, 40 Van Natta 537 (1988).

Dr. Peterman, claimant's treating neurologist, declared her condition "stable and rateable" on March 30, 1989. He added that claimant would need no further treatment aside from analgesic medication for pain. A month later, Peterman reaffirmed that claimant was medically stationary. Following our review of the medical evidence, we are persuaded that claimant became medically stationary on March 30, 1989.

Claimant has not returned to work. Therefore, temporary disability benefits should have continued until claimant became medically stationary, as directed in our order of reopening. The phrase "until claimant ... is medically stationary" means that the medically stationary date is included within the period for which benefits are awarded. Accordingly, claimant is award temporary disability benefits for March 30, 1989. The Notice of Closure is otherwise affirmed. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. We decline to authorize an attorney fee payable out of compensation because claimant's attorney has not filed an executed retainer agreement with the Board. See OAR 438-15-010(1).

IT IS SO ORDERED.

GREGORY W. FISHER, Claimant
Bennett, et al., Claimant's Attorneys
Julia Philbrook (SAIF), Defense Attorney

WCB 87-16808
October 27, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Knudsen's order that granted claimant an award of permanent total disability. Claimant cross-requests review of that portion of the Referee's order that found he had not timely appealed SAIF's partial denial of his current psychological condition. We reverse on the issue of permanent total disability, but, otherwise, affirm.

ISSUE

1. Whether claimant is time-barred from contesting SAIF's partial denial of his current psychological condition.

2. Whether claimant is permanently totally disabled and, if not, the extent of his unscheduled permanent disability for a low back condition.

FINDINGS OF FACT

Timeliness

Claimant maintained a post office box at Lents Station, which has a zip code of 97266. Although he does not reside in that zip code area, he utilizes the post office box solely for the receipt of "some magazines" and mail from SAIF. He checks the post office box every two weeks. During July, 1987, and August, 1987, he examined the contents of the post office box on several occasions and actually retrieved disability checks that had been mailed by SAIF.

Mr. Maunu, the station manager at the Lents Station, testified at the hearing. Maunu supervises approximately 60 postal carriers and nine clerk/sorters. He is aware of and enforces U. S. Postal Service policy regarding the delivery of certified mail. It a piece of certified mail with a non-existent zip code is mailed, it is routed by an automatic sorter to a manual, or human sorter. The human sorter examines the post office box number to determine the station where the article of mail should be sent. The first two digits of the post office box number correspond to the last two digits of the station zip code. Claimant's post office box number is 66022.

Mr. Maunu identified Exhibit 85-1, an envelope with the SAIF logo and return address postmarked July 31, 1987, in Portland. He specifically identified the writing on the face of the envelope as follows: (1) the mark "LN" meant "left notice"; the marks "8-4, 8-11, 8-12, 8-20, and 8-24," were dates made by one of his clerks, Greg Reese; and (3) the word "unclaimed" was written by Kathryn Zbinden, another clerk.

The mark "left notice" on Exhibit 85-10 signified that the clerk had placed a yellow 3" x 6" postal form in claimant's post office box, which indicated that a certified mail item could be claimed at the counter. Each date on Exhibit 85-1 referred to a new postal form being deposited in claimant's post office box.

The postal forms did not indicate the sender of the item, but only the zip code of origin.

SAIF's denial letters are routinely sent certified mail. If returned, they are stored within the mailing envelope in the claim file. Mr. Wyckoff, a SAIF's claims examiner, identified the denial letter, Exhibit 85-2, contained within the envelope, Exhibit 85-1, as a letter prepared and mailed by SAIF. Wyckoff retrieved Exhibits 85-1 and 85-2 from the claim file in his possession. The address on the denial letter, which showed through the envelope's address window, contained an incorrect zip code of "97226" instead of the correct "97266."

Despite the incorrect zip code, the denial letter was actually delivered to the correct address no later than August 4, 1987. Since claimant examined the contents of the post office box every 14 days, he examined the contents of the box on at least two occasions between August 4, 1987, and September 1, 1987. While doing so, he retrieved his disability checks, but chose not to collect his certified mail. He knew that the yellow postal forms indicated the delivery of certified mail from SAIF.

SAIF mailed its denial from Portland, on July 31, 1987. The denial was later returned to SAIF unclaimed. Thereafter, on November 4, 1987, claimant filed his request for hearing.

Permanent Total Disability

Claimant, 37 at the hearing, underwent a non-work related L4-5 laminectomy in 1973. Shortly thereafter, he apparently returned to regular work as a bartender. In October, 1976, he compensably injured his low back, while working as a construction laborer. He was examined by Dr. Kiest, an orthopedic surgeon, who eventually diagnosed a herniated disc at L4-5 and performed a laminectomy in March, 1977. One year later, Kiest performed another laminectomy after detecting a disc herniation at L3-4. Claimant's low back pain continued, however, and in May, 1979, he underwent an L4 to L5 spinal fusion performed by Kiest. In June, 1980, he was examined by the Orthopaedic Consultants, who had previously examined him on two occasions. The Consultants assessed his permanent physical impairment as "moderate" and recommended a return to sedentary or light work.

A Determination Order closed claimant's claim on February 11, 1981, with an award of 45 percent unscheduled permanent disability.

After remaining out of work for several years following his 1976 injury, claimant returned to work on February 26, 1981, as a warehouseman. In May, 1982, he experienced increased low back pain, while lifting at work. He was taken off work for one month by Dr. Kiest. In September, 1982, his employer transferred him to an office position to ease the strain on his back. He worked in that capacity until October, 1983, when he was laid-off. Thereafter, he drew unemployment and periodically looked for work as a carpenter.

In April, 1985, a myelogram revealed that claimant had developed a mild bulging disc since the May, 1979, fusion operation. As a result, SAIF voluntarily reopened claimant's claim and he underwent further low back surgeries in June, 1985, and January, 1986.

In May, 1987, SAIF referred claimant to Mr. Lageman, a vocational expert, for a "comprehensive vocational assessment." After evaluating claimant, Lageman concluded that he was employable in several sedentary to light occupations. The Orthopaedic Consultants reexamined claimant in June, 1987, and found, inter alia, that he had moderately severe permanent physical impairment.

A second Determination Order issued in October, 1987, with an additional award of 15 percent unscheduled permanent disability, for a total award of 60 percent.

In December, 1987, Mr. Klienstuber, a vocational expert, was deposed. Klienstuber had never met claimant nor provided any vocational services on his behalf. His opinion that claimant was not employable, was based solely on some unknown documentary materials. (Klienstuber deposition at 4). That same day, Mr. Wentz, a vocational expert, was deposed. Wentz had provided vocational services to claimant since March, 1987. In Wentz's opinion, claimant was employable.

Claimant attended four years of high school, but did not graduate nor obtain a GED certificate. Thereafter, he worked as manual laborer, construction worker, lineman, carpenter, and warehouseman. He experiences constant pain in his low back and has moderately severe permanent physical impairment due to the October, 1976, compensable injury. Although no physician has prescribed pain medication, he regularly obtains Percodan "from a friend" and ingests up to 20 tablets a week.

We accept the Referee's finding that, at the hearing, claimant was neither a reliable nor credible witness.

CONCLUSIONS OF LAW

Timeliness

The Referee found that claimant was time-barred from contesting the merits of the insurer's denial of his alleged psychological condition. See ORS 656.262(6). We agree.

A worker has 60 days in which to request a hearing on a denied claim, unless he can prove good cause for his delay. ORS 656.319(1). Moreover, at the time SAIF issued its denial in this case, our administrative rules provided that a denial must be, inter alia, "delivered by registered or certified mail with return receipt requested." Former OAR 438-05-065.

Subsequent to the Referee's order, the Court of Appeals issued its opinion in United Foam Corp. v. Whiddon, 96 Or App 178 (1989). In Whiddon, the court reversed the Board's conclusion that a denial correctly sent by certified mail and subsequently returned unclaimed, did not begin the 60-day period of ORS 656.319(1). 96 Or App at 178.

Here, SAIF mailed its denial by certified mail on July 31, 1987. It was later returned unclaimed. Therefore, pursuant to Whiddon, had SAIF correctly addressed the denial letter, the 60-day period would have commenced on July 31, 1987. Since it did not, however, we conclude that the 60-day period

began to run on August 18, 1987. By that date, the denial had been correctly delivered and claimant had actually examined the contents of his post office box, but he deliberately chose to ignore the yellow postal form(s) and to not retrieve his certified mail. Moreover, given the limited nature of the type of mail claimant received at his post office box, i.e., magazines and SAIF mail, and considering that the postal forms indicated that the certified mail had been sent from a zip code in Portland, we have found above that claimant knew that the certified mail had been sent from SAIF.

Accordingly, by the time claimant filed his hearing request on November 4, 1987, the 60-day period had expired.

We turn to whether claimant has proven good cause to excuse his late filing. Claimant argues that because he "never actually saw the notice of denial," he has established good cause. We disagree. To prove good cause, claimant must show that his late filing was due to "mistake, inadvertence, surprise or excusable neglect." Anderson v. Publishers Paper Company, 78 Or App 513, 517 (1986). In our view, claimant's deliberate refusal to retrieve his certified mail, which he knew was sent from SAIF, does not establish good cause as defined above.

Permanent Total Disability

Permanent total disability may arise from a worker's physical disability or from a combination of his physical disability and social/vocational factors. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Unless it would be futile, a worker is required to make reasonable efforts to obtain regular gainful employment. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Concluding that claimant was permanently totally disabled, the Referee stated, inter alia: "I find that [claimant's moderately severe permanent impairment] in combination with his preexisting and, now moderately severe, personality disorder, make him permanently totally disabled." We disagree.

First, as we found above, claimant did not timely appeal the insurer's partial-denial of his psychological condition, which has been diagnosed as a personality disorder. That condition is, therefore, not compensable.

Second, pursuant to ORS 656.206(1), a worker's "preexisting disability" may properly be considered in assessing whether he is permanently totally disabled. However, on this record, the preponderance of the evidence does not establish that claimant's underlying personality disorder was disabling prior to his compensable injury of October, 1976. That is, there is nothing to indicate that claimant's personality disorder either limited his ability to work or required medical treatment, until well after October, 1976. Disability which arises after a compensable injury and which is not caused by the injury may not be considered in determining permanent total disability. Weyerhaeuser v. Rees, 85 Or App 325 (1987); Emmons v. SAIF, 34 Or App 603 (1978). Accordingly, the Referee erred in considering claimant's personality disorder in determining whether he was permanently totally disabled.

Last, although claimant has a moderately severe

permanent physical low back impairment, Exs. 58-1 & 70-5, no physician has stated that he is physically unable to regularly perform suitable work. Although his limited education and employment experience are impediments to suitable employment in sedentary occupations, he is relatively young at age 37. Moreover, the persuasive vocational evidence shows that he has the necessary transferable skills to regularly perform suitable sedentary occupations. Mr. Lageman testified that claimant was employable as a "night clerk, a security guard, [and] things such as your unskilled cashiers and canteen operators." (Tr. 242). Mr. Wentz corroborated Lageman's opinion. (Wentz deposition at 17, 31). Mr. Klienstuber's contrary opinion is not persuasive. Unlike both Wentz and Lageman, Klienstuber never observed claimant nor provided any vocational services. His opinion regarding claimant's employability was based solely on certain documents that were provided to him prior to his deposition. (Klienstuber deposition at 3--5).

Under such circumstances, we conclude that claimant is not permanently and totally disabled.

We turn to the extent of claimant's unscheduled permanent disability due to his compensable injury. Considering his moderately severe permanent impairment, his 11th grade education, his work experience in heavy labor, and his limited transferable skills to sedentary occupations, we conclude that claimant is entitled to an additional award of 20 percent unscheduled permanent disability, for a total award of 80 percent.

ORDER

The Referee's order, dated February 9, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that granted claimant an award of permanent total disability is reversed. In lieu of the Referee's award, claimant is awarded an additional 20 percent (64 degrees) unscheduled permanent disability, for a total award of 80 percent (256 degrees). Claimant's attorney's fee shall be adjusted accordingly. All remaining portions of the Referee's order are affirmed.

HATTIE L. GOODRICH, Claimant — WCB 86-16589
Hayner, et al., Claimant's Attorneys — October 27, 1989
Schwabe, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Speer and Howell.

The self-insured employer requests review of Referee Hettle's order that: (1) set aside its denial of claimant's claim for a stress-induced psychological condition; and (2) assessed a penalty and accompanying attorney fee for an allegedly unreasonable denial. We affirm in part and reverse in part.

ISSUES

1. Compensability. Whether claimant's stress-induced psychological condition resulted from the circumstances and manner of her discharge, or instead resulted from the stress of her actual or anticipated unemployment?

2. Penalties and Attorney Fees.

FINDINGS OF FACT

The Board adopts the Referee's Findings.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Board adopts the Referee's Opinion with regard to the issue of the compensability of claimant's claim.

Penalties and Attorney Fees

The Referee assessed a penalty and accompanying attorney fee, in part, based upon his determination that Dr. Colbach's November 17, 1986 report did not provide a reasonable basis for the denial. We agree with the Referee's conclusion that, overall, the report supports the compensability of claimant's claim. However, portions of that report can be reasonably interpreted to support the employer's denial, so that the employer may have had a legitimate doubt as to its liability under the claim. Accordingly, imposition of a penalty and associated attorney fee is not warranted. See Judith L. Rotella, 39 Van Natta 415 (1987).

ORDER

The Referee's order dated February 5, 1988 is reversed in part and affirmed in part. That portion of the order that asssessed a penalty and an attorney fee for an unreasonable denial is reversed. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $1,715.

THADDEUS G. GORECKI, Claimant	Own Motion 87-0356M
Vick & Gutzler, Claimant's Attorneys	October 27, 1989
SAIF Corp Legal, Defense Attorney	Own Motion Order Reviewing Self-Closure

Claimant requests review of the SAIF Corporation's March 27, 1989, Notice of Closure, which terminated temporary disability benefits as of December 20, 1987, and declared claimant medically stationary as of January 9, 1987. Claimant contends that he is entitled to an award of permanent disability.

Claimant's claim was reopened by Own Motion Order on July 5, 1988. Because the claim was reopened after January 1, 1988, this case is governed by current "own motion" law. See Or Laws 1987, ch 884, §§ 37, 62, 63; OAR 438-05-010. Under current own motion law, the Board's authority to award additional compensation on post-1965 claims is limited to temporary disability benefits. See ORS 656.278(1)(a) Consequently, we have no authority to award claimant any additional permanent disability. Orville D. Shipman, 40 Van Natta 537 (1988).

In reopening this neck and low back injury claim, we directed SAIF to pay temporary disability benefits until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. We further directed SAIF to close the claim pursuant to OAR 438-12-055 "when appropriate," i.e., when claimant becomes medically stationary. We are not persuaded that

claimant has either returned to regular work or become medically stationary.

Dr. Noren, the treating chiropractor, released claimant for modified work with various physical restrictions on December 21, 1987. There is no evidence in the record to indicate that claimant returned to his regular work at his regular wage. Consequently, temporary disability benefits should not have been terminated in December, 1987.

On Form 828 (Supplemental Medical Report) dated January 10, 1989, Noren declared claimant's low back condition medically stationary but declined to declare the upper back condition stationary, apparently due to what she described as a flareup of cervicothoracic and right upper extremity pain. More than a month later, Noren declared claimant medically stationary as of January 9, 1989; however, she also reported recurrent cervicothoracic joint dysfunctions with associated muscular spasms and inflammation. Noren advised that claimant had been involved in a motor vehicle accident (MVA) on February 1, 1989, which injured the cervicothoracic and right shoulder areas. She indicated that the cervicothoracic condition had not yet returned to pre-MVA state. A myelogram on June 7, 1989, revealed evidence of a herniated cervical disc.

There is no medical report in this record declaring claimant's upper back condition medically stationary prior to the non-industrial MVA. Indeed, the Form 828 of January 9, 1989, suggests that claimant had persistent cervicothoracic problems up to the time of the MVA. Moreover, although the MVA caused additional cervicothoracic problems, there is insufficient evidence to show that the intervening MVA-related injury was of sufficient magnitude to relieve SAIF of further responsibility for continuing cervicothoracic problems. Absent such evidence, SAIF should neither have closed this claim nor terminated temporary disability benefits until it received medical evidence declaring claimant medically stationary with regard to his continuing upper back condition. There is no such evidence in this record.

Accordingly, SAIF's Notice of Closure is set aside as premature and claimant's claim is remanded to SAIF for further processing according to law. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. We decline to authorize an attorney fee payable out of compensation because claimant's attorney has not filed an executed retainer agreement with the Board. See OAR 438-15-010(1). When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

GLENDA M. GRAVES, Claimant
Rasmussen & Henry, Claimant's Attorneys
H. Thomas Andersen (SAIF), Defense Attorney
Phillip Nyburg, Defense Attorney

WCB 87-14666 & 87-06078
October 27, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Huffman's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for right carpal tunnel syndrome; and (2) upheld the SAIF Corporation's denial of the same

condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

Claimant experienced pain in her right wrist extending to her shoulder in 1983 while working for SAIF's insured at an assembly line position. The work required repetitive use of her hands while filling and plugging spice bottles. Claimant is right-hand dominant. She sought no medical treatment at the time.

After leaving her assembly line position, claimant was employed at various times as an in-house care provider, a phone solicitor, and a motel maid.

Commencing in July 1986, claimant was employed by Liberty Northwest's insured as a housekeeper/maid. She worked four hours a day, five days per week. In all, she worked a total of 108 hours during the employment. Her job duties included changing bed linens, dusting, scrubbing restroom fixtures, and cleaning kitchens.

Initially, claimant spent 30 minutes cleaning each room. However, approximately three weeks into her employment, claimant was instructed to spend no more than 20 minutes on each room. When she attempted to speed up her work, she experienced a recurrence of her prior right hand, wrist and arm symptoms. Claimant subsequently quit her employment as a result of these symptoms.

More than two months later, claimant sought medical attention from Dr. Weinstein. Dr. Weinstein referred claimant to Dr. Golden, neurosurgeon, for evaluation of possible right carpal tunnel syndrome. Dr. Golden's examination and additional testing confirmed a diagnosis of moderate right carpal tunnel syndrome. Since terminating her employment, claimant had also begun to experience mild symptoms in her left extremity. Testing by Dr. Golden also confirmed mild left carpal tunnel problems.

Claimant is not a reliable witness.

CONCLUSIONS OF LAW AND OPINION

Reliability

We adopt the Referee's discussion of claimant's unreliability as a witness with the following supplementation.

In addition to claimant's marked inability to remember places and periods of employment, her testimony was both internally inconsistent as well as inconsistent with prior medical histories. In this regard, claimant testified on direct examination that she experienced pain in both her right and left hands and arms during her employment with Liberty Northwest's insured. (Tr. 13). However, on cross-examination, claimant testified that she did not develop left-sided complaints until after terminating her employment with Liberty Northwest's insured. (Tr. 20).

Similarly, claimant stated on direct examination that no activities other than her work activities seemed to cause problems

with her hands. (Tr. 14). During cross-examination, however, she testified that general housekeeping activities caused her to experience symptoms. (Tr. 21). In addition, the January 27, 1988 report of Dr. Button, hand surgeon, related continuing symptoms when claimant engaged in daily activities such as writing, curling her hair, and driving.

Further, claimant testified that her symptoms totally resolved during the period of time between her employment with SAIF's insured and her employment with Liberty Northwest's insured. By contrast, Dr. Button's January 27, 1988 report noted occasional symptomatic flare-ups during this period with normal activities of daily living.

In sum, claimant's testimony on questions important to proving her claim is so vague and inconsistent as to be unreliable.

Compensability

In order to establish a compensable occupational disease, claimant must prove that her work exposure was the major cause of the onset or worsening of her carpal tunnel disease. Former ORS 656.802(1)(a); Devereaux v. North Pacific Ins. Co., 74 Or App 388, 391 (1985). Because claimant has worked for at least two employers whose conditions of employment were capable of causing her carpal tunnel condition, it is sufficient for claimant to prove that her work activities in general resulted in the onset or worsening of the disease. Runft v. SAIF, 303 Or 493, 500 (1987).

Because of claimant's unreliability as a witness, the presence of persuasive medical evidence supporting her claim is crucial to her case. Claimant relies in this regard upon the December 9, 1986 report of Dr. Golden, her treating physician, wherein he stated that claimant's condition "is probably related to her work at [Liberty Northwest's insured].". Absent persuasive reasons to the contrary, we will accord great weight to the opinion of a treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Here we find persuasive reasons not to defer to Dr. Golden's opinion.

Dr. Golden's opinion is persuasive only to the extent that it is founded upon a complete and accurate medical history. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). This is particularly true because Dr. Golden did not commence treating claimant until more than two months after claimant left her employment with Liberty Northwest's insured. Dr. Golden reported in this regard that claimant had experienced "episodes of acute worsening of carpal tunnel syndrome" during her employment with the two insured's. He further reported "complete resolution of her symptoms with conservative treatment following her injury at [SAIF's insured]." However, claimant's unreliability renders us unable to accept this history. As previously noted, Dr. Button reported a less than complete resolution between employments. Moreover, Dr. Golden's report of two episodes of "acute worsening" implies that claimant had experienced hand and arm symptoms prior to her employment with SAIF's insured. This implication is unsupported in the record. Finally, even if Dr. Golden's opinion were accepted, it does no more than relate claimant's condition to her work at Liberty Northwest's insured's. Claimant must show, not merely a relationship, but that her employment was the major contributing cause of her condition. Former ORS 656.802.

Accordingly, claimant's claim is not supported by either reliable lay testimony or persuasive medical testimony. Moreover, persuasive medical opinion exists which refutes the compensability of her claim. In this regard, Dr. Button, hand surgeon, examined claimant in January, 1988. He opined that claimant's condition was not work related, but was instead idiopathic. In reaching this decision, he relied upon the brevity of claimant's work exposures and the fact that claimant had developed left-sided problems post-employment.

In sum, we conclude that claimant has failed to prove that her work exposures were the major cause of the onset of her carpal tunnel disease.

Responsibility

Because claimant has failed to prove the compensability of her claim, the question of responsibility for her condition is moot.

ORDER

The Referee's order dated March 2, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $720, payable by Liberty Northwest Insurance Corporation to its counsel.

SANDRA J. LAMB, Claimant — WCB 88-00359
Phil H. Ringle, Jr., Claimant's Attorney — October 27, 1989
Cummins, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Hoguet's order that set aside its aggravation denial of claimant's right wrist condition. On review, the issue is aggravation.

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

After the Referee issued his order, the Court of Appeals issued its decision on remand in the case of Gwynn v. SAIF, 91 Or App 84 (1988), and the Supreme Court issued it decision in Perry v. SAIF, 307 Or 654 (1989). Here, the preponderance of the evidence does not support a finding that at the time of the last arrangement of compensation (i.e., the March 16, 1987, Determination Order, which granted no award for permanent disability), the parties contemplated future symptomatic flare-ups of claimant's right wrist condition. See Ex. 12-2. Therefore, the case of Gwynn v. SAIF, 304 Or 345, on rem 91 Or App 84 (1988), which addressed the issue of whether the worker's flare-up exceeded that which was contemplated at the time of his last award, does not apply here. Claimant must prove a worsening, as a matter of fact. Perry, supra, 307 Or at 657.

On this record, we agree with the Referee that claimant has proven a worsened right wrist condition, as a matter of fact, resulting from the compensable 1986 injury.

ORDER

The Referee's order, dated April 25, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,288.50.

DONALD L. LOWE, Claimant — WCB 89-06726
Durham, Drummonds, et al., Claimant's Attorneys — October 27, 1989
Kenneth Russell (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Harri's order that dismissed claimant's hearing request on the grounds that it had been withdrawn. The SAIF Corporation has moved for an order dismissing claimant's request, contending that "there is no appealable order" from which to request review. We deny the motion and affirm the Referee's order.

FINDINGS

In April 1989 claimant requested a hearing, noting that the "primary issue" was the "appropriate rate of timeloss payments made by SAIF." Claimant also raised as an issue entitlement to medical treatment. Thereafter, a hearing was scheduled. Prior to the scheduled hearing, claimant's then-attorney advised the Hearings Division that claimant had withdrawn his hearing request "without prejudice."

The Referee's Order of Dismissal issued July 6, 1989. The order did not indicate whether the hearing request had been dismissed with or without prejudice. The order contained a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On August 2, 1989, claimant, through his then-attorney of record, mailed by certified mail a request for Board review of the Referee's order. The request included a certificate of personal service by mail upon the employer and its insured.

ULTIMATE FINDINGS

Claimant's request for review was mailed to the Board, and copies were provided to the remaining parties to the proceeding, within 30 days from the Referee's order. Claimant withdrew his request for hearing. The dismissal order did not state whether the hearing request had been dismissed with or without prejudice.

CONCLUSIONS

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

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b).

Here, the 30th day after the Referee's July 6, 1989 order was August 5, 1989, a Saturday. Thus, the last day to timely submit a request for Board review of the Referee's order was Monday August 7, 1989. See ORS 174.120. Since claimant's request for Board review was mailed by certified mail on August 2, 1989, it is timely. See ORS 656.289(3); OAR 438-05-046(1)(b).

Furthermore, claimant's request for review is accompanied by a certificate of personal service attesting to the fact that a copy of the request was mailed to SAIF and its insured on August 2, 1989. Inasmuch as service by mail is complete upon mailing, claimant's notice is timely. See ORS 656.295(2); OAR 438-05-046(1)(b).

SAIF contends that the request for review was "improper as there is no appealable order." We disagree.

As a result of the Referee's order, claimant's request for hearing concerning the issues of temporary disability compensation and current medical treatment 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, 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).

Because claimant timely requested Board review, the Referee's dismissal order has not become final. See ORS 656.289(3). 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). Therefore, the issue of whether claimant withdrew his hearing request remains viable. Accordingly, the motion to dismiss is denied.

We proceed to the merits. It is our policy to interpret any dismissal order issued by the Hearings Division as an order of "dismissal without prejudice," unless the order states otherwise. Robert L. Murphy, 40 Van Natta 442 (1988). Thus, absent any reference to "prejudice" in a dismissal order, such an order would not have any preclusive effect on subsequent litigation. Glenn L. Woodraska, 41 Van Natta 1472 (September 20, 1989).

Here, claimant's then-attorney of record sent a letter to the Referee that was scheduled to preside over the hearing. The letter confirmed a telephone conversation in which the Referee was advised that claimant had withdrawn his hearing request "without prejudice." Thereafter, a dismissal order issued, stating that claimant had withdrawn his hearing request. The order did not state whether the hearing request was dismissed with or without prejudice.

After review of this record, we find no evidence rebutting the letter from claimant's then-attorney. Consequently, we conclude that claimant withdrew his hearing request. Yet,

since the dismissal order did not state that the dismissal was "with prejudice", we further hold that the dismissal was "without prejudice." Therefore, the dismissal order will have no preclusive effect on subsequent litigation. See Woodraska, supra.

ORDER

The Referee's order dated July 6, 1989 is affirmed.

DANA MADRID, Claimant
Francesconi & Associates, Claimant's Attorneys
Julia Philbrook (SAIF), Defense Attorney

WCB 88-13667 & 88-16444
October 27, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Quillinan's order that: (1) awarded 14.5 percent (46.4 degrees) unscheduled permanent disability for his back condition, beyond a Determination Order that did not award permanent disability; and (2) declined to determine the extent of his unscheduled permanent disability for a psychological condition. We modify in part, reverse in part, and affirm in part.

ISSUES

1. The extent of claimant's unscheduled permanent disability for his low back condition.

2. The extent of claimant's unscheduled permanent disability for his psychological condition.

FINDINGS OF FACT

Claimant, 40 at the hearing, has an 11th grade education and no GED certificate. Although his employment since high school has been sporadic, he has been principally employed as a car salesman and lot man, a car washer, a mobile home installer, an asphalt paver, and a furniture salesman.

In November, 1987, claimant compensably sprained his low back, while working as a car salesman for SAIF's insured. Dr. Takacs treated him conservatively. Despite off-and-on symptoms, he continued to work. By late December, 1987, his strain was beginning to resolve.

Claimant sought counseling from Dr. Takacs in January, 1988, for "stresses of the work place." His low back continued to improve with physical therapy.

In February, 1988, claimant filed a mental stress claim, which SAIF accepted as a new claim on May 10, 1988.

Dr. Scherr, claimant's treating psychologist, took claimant off work on February 22, 1988, due to his difficulties with job-related stress.

In April, 1988, claimant was examined by Dr. Martens, an orthopedist, and Dr. Glass, a psychiatrist. Martens found no objective pathology other than some degenerative disc disease at L5-S1, and assessed claimant's permanent physical impairment at zero to minimal.

Claimant was examined by Dr. Turco, a psychiatrist, in July, 1988.

Claimant suffered an anxiety and depression reaction to his work environment.

On July 28, 1988, a Determination Order closed claimant's low back injury claim without an award of unscheduled permanent disability.

The following month, claimant sought medical attention for a flare-up of low back pain.

A second Determination Order issued on September 7, 1988, which, inter alia: (1) awarded no unscheduled permanent disability for claimant's psychological condition; and (2) found that he was medically stationary on July 1, 1988.

Claimant has a mild psychological impairment for his psychosis which has been classified by Dr. Scheer as Class 1 (0-5%).

Claimant continues to receive conservative treatment from Dr. Takacs. He also treats on a weekly basis with Dr. Scherr. He has completed a real estate training course and is currently employed in that field. Due to low back pain, he cannot sit, stand, or walk for more than one hour at a time nor for more than four hours a day. He may only occasionally lift or carry up to 30 pounds. He avoids bending and twisting. His back regularly flares-up while performing domestic activities, such as cleaning the basement.

Claimant was medically stationary August 25, 1988.

Claimant has lost 26 percent of his earning capacity due to his compensable low back injury and 10 percent of his earning capacity due to his compensable psychological condition.

CONCLUSIONS OF LAW

Extent--Low Back

The Referee awarded claimant 14.5 percent unscheduled permanent disability for his low back condition. We modify.

In evaluating the extent of claimant's permanent disability, we apply former OAR 436-35-001, et seq, which was effective at the time of the July 28, 1988, Determination Order. OAR 438-10-005; 438-10-010.

Physical Impairment. Dr. Takacs, the treating physician, and Dr. Martens, who performed the IME, have both submitted reports measuring claimant's loss of range of motion. Dr. Martens' measurements were made in April 1988; Dr Takacs' measurements were made in August 1988. The measurements are basically similar; however, we rely on those of the treating physician, Dr. Takacs, who is more familiar with the claimant and also authored the most recent report.

Dr. Takacs has rated claimant's physical impairment due to loss of range of motion at 10 percent. Ex. 1-2. In doing so, he objectively evaluated claimant's spinal ranges of motion, but

incorrectly applied the corresponding percentage values set forth in former OAR 436-35-360(6), et seq. After correctly applying those range of motion ratings to the corresponding percentage values, we arrive at a total value of 8 percent. Former OAR 436-35-360(10). That value is based on retained degrees of motion as follows: flexion of 40 degrees equal to loss of 5 percent; extension of 25 degrees for a loss of .5 percent; side bending (right and left flexion) of 25 degrees for no value; and left and right rotation of 25 degrees for a value of 1 percent for each side. Claimant's total loss of range of motion is 7.5 percent rounded to 8 percent.

In addition to claimant's 8 percent impairment due to the above loss of motion findings, Dr. Takacs found a 10 percent impairment due to claimant's pain. Ex. 1-2. After reviewing claimant's credible testimony, see Davies v. Hanel Lumber Co., 67 Or App 35 (1984), we are persuaded that he suffers disabling pain, which has permanently limited his ability to sit, stand, walk, lift, bend, and twist. The loss of use or function attributable to his disabling pain is separate and distinct from the loss of range of motion in his spine. See Daniel M. Alire, 41 Van Natta 752 (1989). Accordingly, he receives an additional impairment value of 10 percent based on this loss of use or function, former OAR 436-35-320(1)(a), for a total impairment rating of 18 percent.

Once impairment is established, the factors, under the standards, which modify it, are to be considered. Those factors are:

Age. Claimant is 40 years of age. This is a plus one factor. Former OAR 436-35-290(4).

Education. A plus one factor is assigned for workers, like claimant, who have an 11th grade education and no GED certificate. Former OAR 436-35-300(3)(b).

Skills. At the time of claimant's November, 1987, low back injury, he was successfully employed as a car salesman. The Dictionary of Occupational Titles produced by the U.S. Department of Labor, incorporated by reference under former OAR 436-35-300(4), provides a Specific Vocational Preparation (SVP) of 5 for car salesmen. This was his highest SVP for the proceeding 10 years. This is a plus two factor. Id.

Training. Claimant has not provided any "documentation" of vocational training pursuant to former OAR 436-35-300(5). This is a plus one factor. Former OAR 436-35-300(5)(a).

Adaptability to perform a given job. Claimant is unable to perform his usual work of a car salesman, but has returned to lighter work in the real estate field. This represents a decrease from medium to light-medium work, which provides an adaptability figure of 1.5. Former OAR 436-35-310(1).

Assembling the factors. The age and education factors are added (1 + 1 + 2 + 1 = 5) yielding a figure of 5. Former OAR 436-35-280(4). That figure is then multiplied by the adaptability figure of 1.5, which in turn yields a figure 7.5. Former OAR 436-35-280(6).

Finally, adding the 7.5 figure, supra, to a total physical impairment figure of 18 percent, yields a disability of 25.5 percent. Rounded up to the next highest whole number, former OAR 436-35-280(7), results in an award of 26 percent unscheduled permanent disability for claimant's low back condition.

Extent-Psychological Condition

Finding that claimant's pyschological condition was "prematurely closed," the Referee declined to rate the extent of claimant's unscheduled permanent disability for that condition. We reverse.

The Determination Order of September 7, 1988, closed claimant's psychological stress claim and found that he was medically stationary on July 1, 1988. The Referee adjusted that medically stationary date to August 25, 1988, and awarded additional temporary disability compensation, but, otherwise, approved the Determination Order. Accordingly, despite the Referee's language to the contrary, she did not find that the Determination Order "prematurely closed" claimant's psychological claim. In fact, the Referee found that claimant's psychological condition was medically stationary on August 25, 1988; i.e., prior to the issuance of the September, 1988, Determination Order. As neither party has challenged this finding, we do not disturb it.

Accordingly, we proceed to assess claimant's extent of unscheduled permanent disability due to his compensable psychological condition. We apply former OAR 436-35-001, et seq, which was effective at the time of the September 27, 1988, Determination Order. OAR 438-10-005; 438-10-010.

There is general agreement among the the mental health experts that claimant exhibits signs of a psychoneurosis. Dr. Scherr opined that claimant's symptoms were "characteristic of those found in the section [of the Director's permanent disability standards] on the permanent state of psychoneurosis, Class I 0-5%[,] including anxiety and depressive reactions." Ex. 3b. Likewise, Dr. Glass, diagnosed, inter alia: "Adjustment reaction of adult life with features of depression and anxiety." Ex. O-5. Dr. Turco concurred with Glass' diagnosis, although he did not believe claimant had a personality disorder or suffered permanent impairment from this stress claim. Ex. Q2-3.

As there is a difference of opinion between the medical experts regarding permanent disability, we find Dr. Scheer, the treating psychologist persuasive. Dr. Scheer has had an opportunity to observe the claimant over a period of time. His report is also closer in time to the hearing. Deference should be given to the treating physician unless there are persuasive reasons to do otherwise. Accordingly, we find that pursuant to former OAR 436-35-400(4)(a), et seq, claimant has a Class I permanent psychosis, and a 2.5 percent permanent psychological impairment.

As we found above, the age, the education, and the adaptability factors yield a figure of 7.5. Adding that figure to the psychological impairment figure of 2.5 percent, yields a disability rating of 10 percent.

Clear and Convincing Evidence.

Neither party is prevented or limited from establishing

by clear and convincing evidence that the degree of permanent disability suffered by claimant is more or less than the entitlement indicated by the standards adopted by the Director under ORS 656.726. See ORS 656.283(7); 656.295(5). To be "clear and convincing," the evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987).

Here, claimant asserts that his credible testimony concerning his pain and physical limitations, as well as Dr. Takacs' opinion that he suffers 10 percent physical impairment due to pain, establishes by clear and convincing evidence that his award pursuant to the standards was insufficient. This assertion is based on the premise that the Referee did not consider disabling pain in her application of the standards.

As we found above, however, we have considered claimant's disabling pain in our application of the standards. Furthermore, after conducting our review of the medical and lay evidence, we are not persuaded that claimant's pain establishes by clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards.

ORDER

The Referee's order, dated November 7, 1988, is modified in part, reversed in part, and affirmed in part. That portion of the Referee's order that awarded claimant 14.5 percent unscheduled permanent disability for his low back condition is modified. In addition to the Referee's award of 14.5 percent (46.4 degrees), claimant is awarded 11.5 percent (36.8 degrees) unscheduled permanent disability for a total award to date of 26 percent (83.2 degrees) for the low back. Those portions of the Referee's order that found claimant's psychological condition "prematurely closed" and that declined to rate his extent of unscheduled permanent disability for that condition are reversed. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for his psychological condition. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded an approved fee equal to 25 percent of the increased compensation awarded by this order, not to exceed $3,800 in total fees awarded by the Referee and the Board.

BILLY J. McADAMS, Claimant — WCB 87-15975
David Hollander & Associates, Claimant's Attorneys — October 27, 1989
Rankin, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of those portions of Referee Bennett's order that: (1) affirmed Referee Lipton's prior ruling concerning its right to depose Dr. Turco, a psychiatrist; and (2) set aside its denial of claimant's psychological condition. On review, the issues are evidentiary and compensability.

The Board affirms the order of the Referee.

FINDINGS OF FACT

Evidentiary Matter

The parties initially proceeded to hearing on February 17, 1987. Before admitting any exhibits, Referee Bennett noted that the record would remain open beyond February 17, 1987, for the deposition of Dr. Turco. Exhibits 1 through 108 were then admitted. Exhibit 104 is a narrative report from Turco written in response to a letter from the employer's counsel, dated September 11, 1987.

Claimant sought to depose Dr. Turco because the employer's counsel had declined to disclose certain documents from Turco, unless he was deposed. On March 4, 1987, the parties gathered to depose Turco. After reviewing the requested documents, claimant elected to not question Turco. He did wish, however, to submit into evidence the September, 1987, letter. Ex. 114-16 & 17. The employer then sought to "cross-examine" Turco. Claimant objected. At that point, the parties apparently telephoned Referee Lipton, who ruled that the employer could question Turco solely with respect to the matters contained in the September, 1987, letter.

When the hearing before Referee Bennett reconvened on March 7, 1988, the employer's counsel requested that the record remain open so that he could further depose Dr. Turco. The employer's counsel sought to question Turco concerning matters outside the scope of the the September, 1987, letter. Referee Bennett ruled against the employer, although he allowed it to depose Turco and to submit the transcription of the deposition, see Ex. 118, as an "offer of proof."

Compensability

The Board adopts the Referee's findings on the merits of the compensability issue with the following supplementation. The compensable injury of November, 1984, was a material contributing cause to the onset of claimant's psychological condition.

CONCLUSIONS OF LAW

Evidentiary Matter

The employer submitted a narrative report from Dr. Turco, Ex. 104, which was admitted. The only reason Turco was deposed in the first place solely because the employer declined to disclose Turco's notes, unless he was deposed. Consequently, claimant made arrangements to deposed Turco. After reviewing Turco's notes, claimant elected not to question Turco. He did, however, submit the September, 1987, letter, which was later admitted. Referee Lipton permitted the employer to "cross-examine" Turco regarding the contents of that letter.

"Substantial justice" was served. See ORS 656.283(7). Dr. Turco's opinion is in evidence. (Ex. 104 & 114). Had the employer wanted to further question Turco, it could have called him to the witness stand at the hearing. It did not do so. Referee Lipton did not err in limiting cross-examinatin by way of a prehearing deposition. Neither did the Referee abuse his discretion in declining to allow the employer to further develop Turco's opinion, by way of a post-hearing deposition.

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As we found above, however, we have considered claimant's disabling pain in our application of the standards. Furthermore, after conducting our review of the medical and lay evidence, we are not persuaded that claimant's pain establishes by clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards.

ORDER

The Referee's order, dated November 7, 1988, is modified in part, reversed in part, and affirmed in part. That portion of the Referee's order that awarded claimant 14.5 percent unscheduled permanent disability for his low back condition is modified. In addition to the Referee's award of 14.5 percent (46.4 degrees), claimant is awarded 11.5 percent (36.8 degrees) unscheduled permanent disability for a total award to date of 26 percent (83.2 degrees) for the low back. Those portions of the Referee's order that found claimant's psychological condition "prematurely closed" and that declined to rate his extent of unscheduled permanent disability for that condition are reversed. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for his psychological condition. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded an approved fee equal to 25 percent of the increased compensation awarded by this order, not to exceed $3,800 in total fees awarded by the Referee and the Board.

BILLY J. McADAMS, Claimant — WCB 87-15975
David Hollander & Associates, Claimant's Attorneys — October 27, 1989
Rankin, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Crider and Nichols.

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Compensability

The Board adopts the Referee's findings on the merits of the compensability issue with the following supplementation. The compensable injury of November, 1984, was a material contributing cause to the onset of claimant's psychological condition.

CONCLUSIONS OF LAW

Evidentiary Matter

The employer submitted a narrative report from Dr. Turco, Ex. 104, which was admitted. The only reason Turco was deposed in the first place solely because the employer declined to disclose Turco's notes, unless he was deposed. Consequently, claimant made arrangements to deposed Turco. After reviewing Turco's notes, claimant elected not to question Turco. He did, however, submit the September, 1987, letter, which was later admitted. Referee Lipton permitted the employer to "cross-examine" Turco regarding the contents of that letter.

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As we found above, however, we have considered claimant's disabling pain in our application of the standards. Furthermore, after conducting our review of the medical and lay evidence, we are not persuaded that claimant's pain establishes by clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards.

ORDER

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BILLY J. McADAMS, Claimant — WCB 87-15975
David Hollander & Associates, Claimant's Attorneys — October 27, 1989
Rankin, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of those portions of Referee Bennett's order that: (1) affirmed Referee Lipton's prior ruling concerning its right to depose Dr. Turco, a psychiatrist; and (2) set aside its denial of claimant's psychological condition. On review, the issues are evidentiary and compensability.

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Compensability

The Board adopts the Referee's findings on the merits of the compensability issue with the following supplementation. The compensable injury of November, 1984, was a material contributing cause to the onset of claimant's psychological condition.

CONCLUSIONS OF LAW

Evidentiary Matter

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ORDER

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BILLY J. McADAMS, Claimant — WCB 87-15975
David Hollander & Associates, Claimant's Attorneys — October 27, 1989
Rankin, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of those portions of Referee Bennett's order that: (1) affirmed Referee Lipton's prior ruling concerning its right to depose Dr. Turco, a psychiatrist; and (2) set aside its denial of claimant's psychological condition. On review, the issues are evidentiary and compensability.

The Board affirms the order of the Referee.

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Compensability

The Board adopts the Referee's findings on the merits of the compensability issue with the following supplementation. The compensable injury of November, 1984, was a material contributing cause to the onset of claimant's psychological condition.

CONCLUSIONS OF LAW

Evidentiary Matter

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"Substantial justice" was served. See ORS 656.283(7). Dr. Turco's opinion is in evidence. (Ex. 104 & 114). Had the employer wanted to further question Turco, it could have called him to the witness stand at the hearing. It did not do so. Referee Lipton did not err in limiting cross-examinatin by way of a prehearing deposition. Neither did the Referee abuse his discretion in declining to allow the employer to further develop Turco's opinion, by way of a post-hearing deposition.

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As we found above, however, we have considered claimant's disabling pain in our application of the standards. Furthermore, after conducting our review of the medical and lay evidence, we are not persuaded that claimant's pain establishes by clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards.

ORDER

The Referee's order, dated November 7, 1988, is modified in part, reversed in part, and affirmed in part. That portion of the Referee's order that awarded claimant 14.5 percent unscheduled permanent disability for his low back condition is modified. In addition to the Referee's award of 14.5 percent (46.4 degrees), claimant is awarded 11.5 percent (36.8 degrees) unscheduled permanent disability for a total award to date of 26 percent (83.2 degrees) for the low back. Those portions of the Referee's order that found claimant's psychological condition "prematurely closed" and that declined to rate his extent of unscheduled permanent disability for that condition are reversed. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for his psychological condition. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded an approved fee equal to 25 percent of the increased compensation awarded by this order, not to exceed $3,800 in total fees awarded by the Referee and the Board.

BILLY J. McADAMS, Claimant — WCB 87-15975
David Hollander & Associates, Claimant's Attorneys — October 27, 1989
Rankin, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of those portions of Referee Bennett's order that: (1) affirmed Referee Lipton's prior ruling concerning its right to depose Dr. Turco, a psychiatrist; and (2) set aside its denial of claimant's psychological condition. On review, the issues are evidentiary and compensability.

The Board affirms the order of the Referee.

FINDINGS OF FACT

Evidentiary Matter

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Compensability

The Board adopts the Referee's findings on the merits of the compensability issue with the following supplementation. The compensable injury of November, 1984, was a material contributing cause to the onset of claimant's psychological condition.

CONCLUSIONS OF LAW

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The employer submitted a narrative report from Dr. Turco, Ex. 104, which was admitted. The only reason Turco was deposed in the first place solely because the employer declined to disclose Turco's notes, unless he was deposed. Consequently, claimant made arrangements to deposed Turco. After reviewing Turco's notes, claimant elected not to question Turco. He did, however, submit the September, 1987, letter, which was later admitted. Referee Lipton permitted the employer to "cross-examine" Turco regarding the contents of that letter.

"Substantial justice" was served. See ORS 656.283(7). Dr. Turco's opinion is in evidence. (Ex. 104 & 114). Had the employer wanted to further question Turco, it could have called him to the witness stand at the hearing. It did not do so. Referee Lipton did not err in limiting cross-examinatin by way of a prehearing deposition. Neither did the Referee abuse his discretion in declining to allow the employer to further develop Turco's opinion, by way of a post-hearing deposition.

Compensability

The Board adopts the Referee's conclusions on the issue of the compensability of claimant's psychological condition.

Claimant's attorney is entitled to an assessed fee for his services on Board review. ORS 656.382(2). However, inasmuch as, to date, we have not received a statement of services from claimant's attorney, we cannot presently award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order, dated March 31, 1988, is affirmed. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $2,198.

GENE L. PELTON, Claimant — WCB 87-15344
Lindstedt, Buono, et al., Claimant's Attorneys — October 27, 1989
Schwabe, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee Shebley's order that: (1) set aside its denial of claimant's claim for a low back injury; and (2) assessed a penalty and associated attorney fee for an allegedly unreasonable and untimely denial. In his brief on review, claimant contends that he is entitled to additional temporary disability compensation. We affirm in part and reverse in part.

ISSUES

1. Compensability. Whether claimant has proven the occurrence of an on-the-job low back injury?

2. Temporary Disability Compensation.

3. Penalties and Attorney Fees.

FINDINGS OF FACT

The Board adopts the Referee's factual findings beginning on page 1 of his order and continuing through the second full paragraph on page 2 of the order. In addition, we make the following supplemental findings.

Prior to the incident on May 18, 1987, claimant filed a workers' compensation claim for a neck and shoulder injury alleged to have occurred on April 1, 1987. This claim was denied by the insurer on July 7, 1987.

From May 20, 1987 until July 13, 1987, claimant was fully compensated for his lost wages while off work through a combination of temporary total disability payments paid pursuant to his April 1, 1987 claim and accrued vacation pay. Claimant returned to work on Monday, July 13, 1987, but he only worked a few hours due to an ankle sprain he incurred while playing golf on his vacation. He remained off work the remainder of the week due to the ankle sprain.

Claimant returned to work on July 20, 1987. He worked

his normal hours on the 20th and the 21st. However, Dr. Holman subsequently restricted claimant to four-hour work days commencing July 22, 1987. He worked four-hour days through July 31, 1987. Claimant was then off work from August 3 through August 5, 1987, due to an unrelated right foot infection. He resumed four-hour work days on August 6th and 7th. Commencing on August 10, 1987, claimant worked his normal hours for his regular wages.

The insurer issued a denial of claimant's May 18, 1987 injury claim on September 3, 1987.

Claimant continued to work his normal hours through Septmeber 22, 1987. On September 23, 1987, claimant experienced an exacerbation of his back symptoms upon sneezing at work. He was then off work through October 2, 1987. He returned to work the following Monday, October 5, 1987. He continued to work full time for his regular wage at a light duty position through the date of hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant's credibility is central to this case. The Referee found claimant to be credible. On review, the insurer continues to challenge claimant's credibility based upon alleged inconsistencies in the record. The Referee's credibility finding is based upon his review of the record and the content of claimant's testimony rather than claimant's demeanor. Therefore, we do not defer to the Referee's finding on this issue. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Our examination of the alleged inconsistencies between the documentary record and claimant's testimony persuades us that the Referee's credibility finding is correct. For example, the insurer contends that, at hearing, claimant falsely denied complaining of low back pain to his treating physician following his April 1, 1987 injury. The insurer notes that the physician's first medical report following the April injury lists low back pain as a complaint on the form. However, claimant did not deny complaining of low back pain. Rather, he denied having made a claim for his low back. Claimant's statement is accurate; his April 1987 claim was for his neck and shoulder. Moreover, his testimony at hearing was that he could not recall whether he had mentioned low back complaints to his treating physician; he did not deny having mentioned such complaints.

In addition, the Referee concluded that two independent medical examiners believed claimant's history of an at-work injury. The insurer argues that we should reject this conclusion because the medical examiners merely repeat claimant's history of an on-the-job injury without asserting any independent findings on compensability. However, one of those examiners, Dr. Duncan, chiropractor, was sufficiently persuaded by claimant's examination to impose a lifting limitation on claimant and to approve one additional month of chiropractic manipulation by claimant's treating physician. Therefore, while Dr. Duncan does not expressly attribute claimant's condition to an at-work injury, he does implicitly accept the occurrence of an injury requiring treatment. Moreover, there is no suggestion in the record that claimant exprerienced any off-the-job injury to his low back.

Finally, the insurer argues that claimant's post-injury activities hoeing his garden and playing in a softball game should cause us to question claimant's report of an injury. Such activities are clearly relevant considerations when the time arrives to rate claimant's permanent disabilty, if any, resulting from this injury. However, in light of the other evidence in the record supporting his claim, we do not conclude that such activities weigh against compensability.

In sum, we conclude that claimant has proven the occurrence of a compensable low back injury on May 18, 1987.

Penalties and Attorney Fees

The Referee found that, at the time the insurer issued its denial, there was no medical or lay evidence casting any doubt upon the compensability of the claim. Therefore, the Referee found the denial to be unreasonable. However, because he also found that claimant was paid his full wage while off work due to the low back injury, the Referee concluded that there were no "amounts then due" upon which to assess a penalty. See ORS 656.262(10).

Alternatively, the Referee found that the insurer had failed to timely accept or deny the claim. See ORS 656.262(6) (claim must be accepted or denied within 60 days). The Referee assessed a 10 percent penalty based upon all temporary disability benefits due claimant between July 19, 1987, the 60th day following the claim, and September 3, 1987, the date of the insurer's denial.

On review, the insurer argues that it had a legitimate doubt as to the compensability of the claim and, therefore, that its denial was not unreasonable. See Norgard v. Rawlinson, 30 Or App 999, 1003 (1977). In addition, the insurer argues that no penalty is assessable for its untimely denial because there were no "amounts then due" upon which to base the penalty.

We are unable to find any reasonable basis as of the date of the denial for the insurer to doubt its liability for the claim. No medical reports at the time cast doubt on the claim. In addition, while claimant's supervisor had observed claimant working in his garden, the insurer viewed this information at the time as calling into question the severity of claimant's injury rather than whether an incident had occurred in the first place. See Ex. 17-1. Moreover, it is unclear whether the softball activities cited by the insurer took place before or after the denial. See Tr. 43-4. Consequently, we are not persuaded that the activities are relevant to an analysis of the reasonableness of that denial.

However, we agree with the insurer's legal analysis. A penalty is assessable only if there are "amounts then due" at the time of the denial upon which to base it. If an employer has paid all interim compensation due until the denial, then there would be no "amounts then due," and no penalty could be assessed. Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988). This is true whether liability for the penalty results from an unreasonable denial or a late denial.

As previously noted, the Referee found that claimant was paid his full wage while off work due to his low back injury.

Claimant testified that he was paid his full wage through the end of June 1987. Thereafter, he missed work for a variety of reasons including a two-week vacation, an ankle sprain suffered while playing golf on his vacation, and a right foot infection. These are all nonwork-related causes. Moreover, at the close of the hearing, the Referee characterized claimant's testimony as stating that he had received all compensation due to him. Claimant did not object to this characterization. We conclude that claimant has failed to prove the existence of any "amounts then due" prior to the insurer's September 3, 1987 denial. Therefore, the Referee's assessment of a penalty was improper. Furthermore, claimant has not proven that the insurer unreasonably resisted the payment of any compensation. An attorney fee may not be awarded. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989).

Additional Temporary Disability

Claimant argues entitlement to additional temporary disability benefits for the period during September 1987 when he was off work following a sneezing incident which exacerbated his back symptoms. The insurer argues that claimant is not entitled to the requested relief because he did not seek any additional compensation following the September incident. We reject the insurer's inference that claimant need file a separate claim in order to obtain compensation for this period. An injured worker is entitled to time loss benefits for all periods during which he or she is off work as a result of a compensable injury. Pursuant to our decision, claimant has established a compensable claim. The insurer is required to process the claim accordingly.

ORDER

The Referee's order dated January 20, 1988 is affirmed in part and reversed in part. Those portions of the Referee's order that awarded claimant a 10 percent penalty and a $250 assessed attorney fee for the insurer's untimely denial are reversed. The remainder of the order is affirmed. For prevailing on the compensability issue, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $3,440.

PATRICIA R. ROSS, Claimant	Own Motion 88-0118M
Cramer, et al., Claimant's Attorneys	October 27, 1989
SAIF Corp Legal, Defense Attorney	Own Motion Order Reviewing Self-Closure

Claimant requests review of the SAIF Corporation's July 25, 1989, Notice of Closure which terminated temporary disability benefits as of June 27, 1989. Claimant argues that claim closure is premature, and she requests a hearing on that issue.

Claimant's claim was reopened by Own Motion Order dated September 9, 1988. Because the claim was reopened after January 1, 1988, this case is governed by the current "own motion" law. See Or Laws 1987, ch 884, §§ 37, 62; OAR 438-05-010. Under current own motion law, the Board's authority to award further compensation on post-1965 claims is limited to temporary disability benefits. See ORS 656.278(1)(a). Consequently, we now lack the authority to award claimant any additional permanent disability benefits. Orville D. Shipman, 40 Van Natta 537 (1988).

The record is sufficiently developed for our review of the propriety of SAIF's closure. Hence, we deny claimant's request for a hearing in this matter.

Dr. Kendrick, claimant's treating physician, declared her medically stationary on June 27, 1989. Dr. Sulkosky, the treating surgeon, concurred. In September, 1989, claimant saw Sulkosky for left hip pain, which was relieved by injection. Sulkosky was hopeful that the pain would "calm down," but raised the possibility of decompressive surgery if the pain persisted and did not respond to injection. He emphasized, however, that no surgery is anticipated and that claimant is not suffering any significant increase in disability. Given Sulkosky's earlier concurrence with Kendrick's declaration that claimant is medically stationary, we are not persuaded that his subsequent statements establish that at the time of closure there was a reasonable expectation of further material improvement in claimant's condition from medical treatment or the passage of time. We find, therefore, that claimant became medically stationary on June 27, 1989. See ORS 656.005(17). Hence, SAIF's termination of temporary disability benefits as of that date was proper. Accordingly, SAIF's closure of the claim was proper, and claimant's request for further benefits is denied.

IT IS SO ORDERED.

MARIA S. SALINAS, Claimant
Emmons, et al., Claimant's Attorneys
Randy Harris (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 86-00225 & 87-04551
October 27, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Bennett's order which: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld the SAIF Corporation's denial of an aggravation claim for the same condition. Claimant cross-requests review of that portion of the order which declined to assess penalties and related attorney fees for alleged unreasonable claims processing. On review, the issues are responsibility and penalties and related attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We note that the Referee recited a good deal of claimant's testimony. We accept the Referee's finding that claimant was credible. We find that the recited testimony was fact. With that, we adopt the findings of fact as set forth in the "Summary of Evidence" portion of the Referee's order.

CONCLUSIONS OF LAW

Responsibility For Low Back Condition

The Referee concluded that Liberty Northwest was responsible for claimant's current low back condition citing Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). We disagree.

To determine the responsibility issue, it is first

necessary to decide whether or not Liberty Northwest accepted claimant's low back condition as part of her compensable claim. We conclude that Liberty Northwest did not. Liberty Northwest's acceptance only encompassed a left foot strain, and did not mention the low back. Liberty Northwest's acceptance renders it only liable for the injury it specifically accepted. See Georgia-Pacific v. Piwowar, 305 Or 494 (1988). Accordingly, the Kearns presumption is not applicable as there are not two successive accepted injuries to the same body part. See Northwest Farm Bureau v. Wine, 86 Or App 106 (1987).

In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court held that unless work activities at the later employer/insurer independently contribute to the worker's disability (i.e. cause a worsening of the underlying condition) then the worker has sustained a mere recurrence of symptoms and the earlier employer/insurer remains responsible. Accordingly, the June 1986 incident must have independently contributed to a worsening of claimant's underlying back condition for Liberty Northwest to be responsible.

We conclude that the June 1986 incident did not independently contribute to a worsening of claimant's underlying back condition. In December 1986, the Orthopaedic Consultants concluded that claimant's condition had not worsened since claim closure in 1983. However, their findings showed a substantial decrease in degree of flexion, extension, bending and rotation. A May 1987 examination by Western Medical Consultants showed a significant increase in degree of flexion, extension and rotation.

Claimant testified that following the June 1986 incident she experienced increased pain symptoms in her back. She further testified that she experienced some limitation not present prior to the June 1986 incident.

Although the medical evidence and claimant's testimony indicate that she experienced increased symptoms following the June 1986 incident, there is no evidence to suggest that the incident worsened her underlying back condition. Responsibility cannot be shifted on the basis of a symptomatic worsening. Mirich, 81 Or App at 294. Accordingly, responsibility remains with SAIF.

Penalties and Attorney Fees

At hearing, claimant raised the issue of penalties and related attorney fees against Liberty Northwest for an alleged unreasonable denial. The Referee found that Liberty Northwest's conduct was not unreasonable and declined to assess a penalty. On review, claimant contends for the first time that Liberty Northwest should be subject to a penalty for alleged untimely denials.

The issue of untimely denials was not raised at hearing and Liberty Northwest did not have an opportunity to defend against that issue. When an issue is not properly raised before a Referee at hearing, and the record is closed, that issue will not subsequently be considered. Brian J. Shaw, 39 Van Natta 438 (1987). Therefore, we decline to consider it at this late date.

ORDER

The Referee's order, dated November 19, 1987, is reversed in part and affirmed in part. Liberty Northwest's denial is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. For services rendered on review concerning the responsibility issue, claimant's counsel is awarded an assessed fee of $800, payable by SAIF. A client-paid fee, not to exceed $2,094, is approved, payable by Liberty Northwest to its counsel.

ROMILDA WILLIAMS, Claimant — WCB 87-05035
Olson Law Firm, Claimant's Attorney — October 27, 1989
Rick Dawson (SAIF), Defense Attorney — Order on Review
Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Black's order that increased her unscheduled permanent disability award for a right shoulder injury from 40 percent (128 degrees), as awarded by a Determination Order, to 50 percent (160 degrees). The issue is extent of disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the following supplementation. Claimant was 45 years of age at hearing. Although she has an 8th grade education, her reading and math skills are at the 5th grade level. Her work experience has been limited to housekeeping and patient care in the medium to heavy work category. She is currently restricted to light work. Claimant experiences almost constant disabling pain in her right shoulder. As of the date of hearing, she was not working.

CONCLUSIONS OF LAW

In order for claimant to qualify for a permanent disability award, upon closure of her aggravation claim, she must show that she suffered a permanent worsening of her shoulder condition, since the claim was last closed by Determination Order in December 1984. Stepp v. SAIF, 304 Or 375 (1987); Bendix Home Systems v. Alonzo, 81 Or App 450 (1986). In the present case, however, the analysis of this issue is not completely straight forward. Claimant's claim was originally closed by a December, 1984, Determination Order which awarded no permanent disability, even though there was evidence that may have supported a permanent disability award had claimant appealed the Determination Order.

SAIF argues that claimant is not entitled to any permanent disability award because she failed to show a permanent worsening of her condition beyond the approximately 20 percent disability the Referee determined that claimant suffered at the time the claim was first closed. In addition, SAIF contends that claimant is not entitled to a de novo review of her entire disability each time her claim is reopened for aggravation. Therefore, SAIF argues that res judicata prohibits the Referee from presently awarding any disability that should have been awarded by the unappealed Determination Order.

The Referee determined that claimant had shown a worsened condition and had suffered approximately a 70 percent loss of earning capacity due to the compensable injury. However, following essentially the same analysis of the res judicata issue

that SAIF uses on appeal, he reduced the award by 20 percent. The Referee determined that claimant was approximately 20 percent disabled in December 1984, when the claim was first closed with no permanent disability award. He reasoned that, because claimant failed to appeal the December 1984 Determination Order, it became final as a matter of law and the doctrine of res judicata barred relitigation of the issue concerning claimant's entitlement to permanent disability as of that date. See Bendix, supra. While we agree with the Referee that claimant has shown her condition worsened since the last arrangement of compensation, we disagree with his analysis of the res judicata issue.

In reaching our conclusion, we draw from our opinion in Charlotte J. Daza, 40 Van Natta 1206 (1988). In Daza, the claimant's original claim was closed by Determination Order which awarded no permanent disability. The claimant did not appeal. The claimant subsequently filed an aggravation claim. The threshold issue in that case was whether the claimant had shown that her condition had permanently worsened from the date of the last award or arrangement of compensation. Since the original Determination Order closed the claimant's claim with no disability award and because the Determination Order had not been appealed, we held that the claimant need only exhibit a minimal degree of injury related to permanent impairment to meet the Stepp worsening requirement. We reasoned that, as a matter of law, the claimant suffered from zero percent disability, at the time of initial claim closure.

Applying the Daza analysis, we find that, as a matter of law, claimant suffered no permanent disability when her claim was originally closed in December 1984. The Referee erred, therefore, in deducting 20 percent from the present disability award because, as a matter of law, claimant's entire present disability arose after the claim was first closed in December 1984.

Having determined that any permanent disability award to which claimant may presently be entitled, is due to a worsened condition occurring subsequent to the December 1984, Determination Order, we now address the extent issue. We consider the opinion and findings reached by Dr. Martens to be both well reasoned and thorough. Consequently, we find it persuasive. See Somers v. SAIF, 77 Or App 259 (1986). In addition to physical impairment, we consider all of the relevant social, vocational and emotional factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, and not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). Taking these factors into consideration, we conclude a 70 percent unscheduled permanent partial disability award adequately compensates claimant for her right shoulder injury.

ORDER

The Referee's order dated November 3, 1987, is modified. In addition to the Determination Order and Referee's award of 50 percent (160 degrees), claimant is awarded 20 percent (64 degrees), giving her a total award to date of 70 percent (224 degrees) unscheduled permanent disability for a right shoulder injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

NAVIN A. BARNES, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Gail Gage (SAIF), Defense Attorney

WCB 87-13497 & 87-09735
October 30, 1989
Order on Review

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Bennett's order that: (1) set aside its denial of responsibility for claimant's aggravation claim for his current back condition; and (2) upheld United Pacific Insurance Company's denial of responsibility for claimant's "new injury" claim for the same condition. We affirm.

ISSUES

1. Standard of Board review regarding the Referee's determination of responsibility.

2. Responsibility for claimant's current back condition.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

FINDING OF ULTIMATE FACT

We do not find that claimant's work activities with United Pacific's insured independently contributed to either the causation of claimant's cervical symptoms or a worsening of claimant's underlying back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that SAIF was responsible for claimant's current back condition. That conclusion was based on a finding that work activities subsequent to claimant's employment with SAIF did not independently contribute to a worsening of his compensable back injury. We agree with the Referee's decision.

Standard of Board Review

Before addressing the merits of this case, we first must determine the applicable standard of Board review. That determination turns on whether this case is governed by pre-1988 law or by the current law. Under pre-1988 law, the Compliance Section referred disputes that were limited to the issue of responsibility for an otherwise compensable claim to the Board for hearing before a Referee. Former ORS 656.307; OAR 436-60-180(13). If appealed, the Referee's determination of responsibility was subject to the Board's de novo review. ORS 656.295(6); Destael v. Nicolai Co., 80 Or App 596, 600-601 (1986).

Effective January 1, 1988, ORS 656.307 now provides that the Compliance Section shall refer responsibility matters to the Board for formal arbitration before a Referee. If appealed, the Arbitrator/Referee's determination is no longer subject to de novo review. Rather, Board review of responsibility cases is now generally limited to "questions of law." ORS 656.307(2).

We have previously held that the critical event for

determining what law governs a particular responsibility case is the Board's receipt of the Compliance Section's order of referral pursuant to ORS 656.307. Timothy R. Schroeder, 41 Van Natta 568, 570 (1989). If the .307 order is received on or after January 1, 1988, the current law applies; otherwise, pre-1988 law is controlling. Id.

Here, Compliance's order referring this matter to the Board was received on September 23, 1987. Hence, this case is governed by pre-1988 law. See id. Accordingly, this case should have been assigned for hearing, rather than arbitration. See former OAR 436-60-180(13). The failure to do so may compel us to remand this case to the Referee for corrective action, if we determine that this case has been "improperly, incompletely or otherwise insufficiently developed or heard" by the Referee. ORS 656.295(5). Following our review of this record, we do not conclude that this case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. Thus, remand is not warranted and we now proceed to review this case de novo. See ORS 656.295(6); Destael v. Nicolai Co., supra.

Responsibility

We adopt the "OPINION" portion of the Referee's order.

ORDER

The Referee's order dated March 16, 1988, is affirmed.

SUE BELLUCCI, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-05865
October 30, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee McGeorge's order that upheld the insurer's denials of chiropractic treatment. In addition, claimant contends that the Referee improperly refused to continue the hearing to allow submission of additional medical evidence to rebut post-hearing deposition testimony from an independent medical examiner. Specifically, claimant argues that the Referee erred in refusing to admit a rebuttal report from claimant's treating physician. Claimant requests that we consider the treating physician's report on review.

We reject claimant's evidentiary argument. On the merits, we set aside the insurer's denial of all further chiropractic treatment while upholding the insurer's denials of specific treatment.

ISSUES

1. Evidentiary questions.

2. Medical services.

FINDINGS OF FACT

A. Findings on the Merits

Claimant, 35 years of age at hearing, is employed as a cake decorator for a supermarket. She is also self-employed in

graphic design. Additionally, she is active in ballet, jazz and contemporary dance.

On December 24, 1985, claimant sustained a compensable injury to her neck and back when she fell at work. The claim was accepted by the insurer as a nondisabling injury. From the date of her injury to the date of hearing, claimant was under the care of Dr. Mulrooney, chiropractor. As of the date of hearing, she was receiving chiropractic treatments once every two weeks.

Claimant has lost no time from work as a result of her December 1985 injury. She has also continued her graphic design and dance. Since her injury, claimant has modified some of her dance training techniques.

On April 1, 1987, the insurer issued a denial letter which stated, in part:

> "[T]his letter will serve to notify you that we are denying medical payments of any further chiropractic bills as of the date of this letter * * *. You may, however, choose a medical doctor to treat you for your on-the-job injury of December 24, 1985."

Claimant requested a hearing challenging the denial on April 14, 1987.

Additional denial letters were issued on July 7, 1987, August 12, 1987, October 2, 1987, and December 4, 1987. These were denials of specific chiropractic billings. Claimant filed supplemental hearing requests contesting these additional denials.

B. Evidentiary Findings

Hearing was held on November 9, 1987. The record was held open in order to obtain the deposition testimony of Dr. Tilden, an independent chiropractic examiner.

Following several unsuccessful attempts to schedule Dr. Tilden's deposition, the Referee informed the parties on January 11, 1988 that the record would be closed on January 28, 1988.

Dr. Tilden was deposed by the parties on January 25, 1988.

On January 28, 1988, counsel for claimant requested an opportunity to produce rebuttal evidence in response to Dr. Tilden's deposition testimony.

On February 8, 1988, the Referee issued an order denying claimant's request for a continuance.

On February 12, 1988, claimant submitted to the Referee a report from Dr. Mulrooney dated February 9, 1988.

On February 16, 1988, claimant's counsel requested reconsideration of the Referee's February 8, 1988 order denying continuance. An order denying reconsideration was issued by the Referee on February 26, 1988.

FINDINGS OF ULTIMATE FACT

The Referee did not abuse her discretion in denying claimant's request for a continuance following Dr. Tilden's January 25, 1988 deposition.

The insurer's April 1, 1987 denial was addressed to no service rendered. It was entirely prospective in nature.

Claimant has failed to prove that the chiropractic treatments denied by the insurer on July 7, 1987, August 12, 1987, October 2, 1987 and December 4, 1987 are reasonable and necessary as a result of her compensable injury.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

A Referee "may continue a hearing * * * [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence * * *." OAR 438-06-091(3). The rule is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within a Referee's discretion. See Randy L. Kling, 38 Van Natta 1046 (1986).

Here, the Referee allowed the record to remain open for nearly three months. Scheduled deposition dates were postponed three times at the request of claimant. Claimant did not request the continuance until the day the record was to be closed. Under these circumstances, we conclude that the Referee did not abuse her discretion by denying claimant's request that the record remain open. Accordingly, on review we decline to consider Dr. Mulrooney's February 9, 1988 report

Medical Services

Claimant contends that the insurer's April 1, 1987 denial is an impermissible denial of prospective medical treatment. The insurer, on the other hand, asserts that we should interpret the denial restrictively as limited to "ongoing" treatment being provided by Dr. Mulrooney.

The denial is expressly applicable to "any further chiropractic bills as of the date of this letter." The denial cannot be interpreted as anything other than a denial of future treatment. As such, it is impermissible. ORS 656.245; Robert M. Bryant, 41 Van Natta 324 (1989).

On the other hand, the insurer's denials dated July 7, 1987, August 12, 1987, October 2, 1987, and December 4, 1987 were all directed to specific services previously rendered by Dr. Mulrooney. As such, the denials are procedurally proper. As to the merits of those denials, we affirm and adopt the Referee's Opinion.

ORDER

The Referee's order dated February 26, 1988 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the insurer's April 1, 1987 denial is reversed. The

denial is set aside. Claimant's attorney is awarded an assessed fee of $250 for his services on this issue at hearing and on Board review, to be paid by the insurer. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $1,136.

ROGER L. BENNETT, Claimant
Doblie & Associates, Claimant's Attorneys
Breathouwer, et al., Defense Attorneys

WCB 87-02967
October 30, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of Referee Tenenbaum's order which set aside its partial denials of claimant's chiropractic treatment for his low back condition. On review, the issue is medical services.

We affirm.

FINDINGS OF FACT

On August 1981, claimant sustained a compensable low back injury while emptying a garbage can. He treated with Dr. Berovic, chiropractor, who diagnosed acute lumbar sprain/strain with attendant myofascitis. The claim was closed by Notice of Closure, issued September 23, 1982.

On April 4, 1986, claimant again sought treatment with Dr. Berovic. On January 8, 1987, the employer issued a denial which was amended on February 24, 1987. In its denial, the employer denied "any and all further responsibility" for claimant's back condition and resultant medical treatment. The employer further acknowledged it would pay for all medical treatments up to the date of its denial and would provide all benefits "found to be directly related to the original, compensable injury." At hearing, the employer stated that it was denying medical services only. (Tr.2)

CONCLUSIONS OF LAW AND OPINION

Finding claimant's low back complaint related to the compensable injury, the Referee set aside the employer's denials. We agree that the denials should be set aside, but for a different reason.

The employer's denials deny only future medical benefits, while agreeing to pay for all medical treatments up to the date of the denials. The denials are void because the effect of a denial of medical treatment is limited to pre-denial services. Robert M. Bryant, 41 Van Natta 324 (1989); Thomas A. Beasly, 37 Van Natta 1514 (1985).

Claimants are normally entitled to a carrier-paid attorney fee for prevailing against a carrier request for review. See ORS 656.382(2). However, claimant has not submitted a brief on review, and the record does not otherwise document legal representation short of briefing that would support an attorney fee award. Under such circumstances, claimant's attorney is not entitled to a fee on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated October 8, 1987 is affirmed.

EDGAR W. COTTON, Claimant	WCB 87-10838
Royce, et al., Claimant's Attorneys	October 30, 1989
Schwabe, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of those portions of Referee Knudsen's order that: (1) set aside its denial of claimant's occupational disease claim for a low back condition; and (2) assessed a penalty and associated attorney fee for the employer's alleged failure to disclose claim documents. We affirm.

ISSUES

1. Compensability.

2. Penalties and Attorney Fees.

FINDINGS OF FACT

Claimant was employed in a job laying underground cable when, in 1983, he suffered a nonwork-related low back injury. He underwent a laminectomy and discectomy at the L5-S1 level. The physician who performed the surgery subsequently advised against prolonged standing, stooping forward or sitting. Claimant returned to his job laying underground cable.

In January 1987, claimant was transferred to an aerial crew as a lineman. Claimant subsequently reported low back and knee pain following pole climbing activities. These complaints resulted in an additional job transfer in March 1987 to a position as a staff clerk.

Pursuant to his job as a staff clerk, claimant spent a substantial portion of his work day sitting at a desk while performing his job duties. He subsequently experienced increased low back pain as well as right leg pain. The pain began in the morning and increased as the day went on.

In June 1987, claimant sought treatment from Dr. Van Sickle, internist, who prescribed medication and rest. Claimant was off work for the next two months. He was released to return to work in August 1987, however he had not returned to work as of the date of hearing. Nor was he treating with a physician as of the date of hearing. Moreover, his symptoms were substantially improved as of that date.

Claimant spoke with Dr. Williams, the employer's health care officer, several times commencing in July 1987. Dr. Williams became involved in claimant's case as a result of the need to determine claimant's entitlement to employer sickness disability benefits. Dr. Williams kept notes of his conversations with claimant. In addition, he solicited information regarding claimant's condition from Dr. Van Sickle. These documents were not disclosed to claimant until specifically requested during Dr. Williams' testimony at hearing. (See Exs. 15, 16 and 17).

FINDINGS OF ULTIMATE FACT

The materials in Dr. Williams' file regarding claimant are "documents pertaining to" his claim. The employer unreasonably delayed furnishing these claims documents to claimant's counsel.

Claimant suffered a lumbar strain in the spring of 1987 resulting in disability and a need for medical services. His work exposures from March through June of 1987 were the major cause of this condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's discussion of this issue subject to the following supplementation.

The employer argues that claimant did not suffer a separate and distinct low back strain as a result of his work exposures and activities. Instead, the employer argues, claimant merely experienced recurrent symptoms of his preexisting, noncompensable low back condition. Therefore, the employer argues, pursuant to the Court's reasoning in Weller v. Union Carbide 288 Or 27 (1979), the claim is not compensable. See former ORS 656.802(1).

The Referee rejected the employer's argument on the basis that Dr. Van Sickle's testimony and reports establish that claimant experienced a lumbar strain separate from his underlying condition. We agree. While Dr. Van Sickle acknowledged that the term "strain" was very "nonspecific", he testified that, in this case, his diagnosis included muscle strain, or pulling, separate from the degenerative condition. (Tr. 62, 72). Moreover, he also testified that claimant's underlying degenerative condition "predisposed" claimant to lumbar strain. We therefore conclude, as did the Referee, that claimant has proven on this record more than a mere increase of symptoms of his underlying condition. Rather, claimant has established a separate, compensable claim.

Penalties and Attorney Fees

The employer also argues that the Referee's award of penalties and attorney fees for its alleged discovery violation is improper. The employer advances two arguments on this issue. First, the employer contends that Dr. Williams' file did not contain any discoverable documents. Second, the employer asserts that its failure to disclose the documents was not unreasonable. Both of these arguments are premised on the fact that claimant was pursuing a grievance procedure and that these documents dealt exclusively with the grievance procedure, not the workers' compensation claim.

We do not agree with the employer's premise. The documents at issue included chart notes of Dr. Williams' regarding claimant's condition, limitations and history, as well as correspondence from claimant's treating physician. While such information may have been pertinent to claimant's grievance procedure, it was also clearly relevant to his workers'

compensation claim. As such, it should have been disclosed to claimant. OAR 438-07-015. Moreover, the relevance of the documents to the workers' compensation claim was sufficiently apparent that it was unreasonable for the employer not to disclose the information. Under these circumstances the Referee's award of a 15 percent penalty and associated attorney fee was appropriate.

ORDER

The Referee's order, dated February 11, 1988, is affirmed. For services on review concerning the compensibility issue, claimant's attorney is awarded an assessed fee of $900, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $1,756.

RENE L. EAYRS, Claimant
Francesconi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Carl M. Davis, Assistant Attorney General

WCB 85-04729
October 30, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

The insurer requests review of Referee Peterson's order that: (1) found that claimant was a subject worker; (2) found that claimant's low back injury claim was not barred for untimely filing because the employer had knowledge of claimant's injury; and (3) set aside its "de facto" denial of claimant's low back injury claim. The issues on review are "subject worker," untimely filing, and compensability.

The Board affirms and adopts the order of the Referee with the following supplementation on the issue of whether claimant was a subject worker at the time of the industrial accident.

Subject worker

The insurer argues that each female performer was not a subject worker because each was an independent contractor who would be paid only if she succeeded in placing first, second, or third in the "wrestling match." We disagree.

The employer placed newspaper advertisements for female "wrestlers" and featured "wrestling" events on its marquee. The employer maintained a list of "wrestlers" and would call them to request they appear for a weekly match. The employer provided all equipment such as mattresses, baby oil, towels, and the wrestling ring.

A male employee acted as the "Referee" and solicitor of tips. The employer or another employee solicited male customers to participate as wrestlers, for a fee, wearing boxing gloves. The employer supplied the boxing gloves and all female wrestlers shared in the fee. Most, if not all, matches were faked, with the employer's knowledge.

The principal factors showing employment are direct right or exercise of control, method of payment, furnishing of equipment, and right to terminate. Of these, the right of control is the most important factor. See Woody v. Waibel, 276 Or 189 (1976); Bernards v. Wright, 93 Or App 192 (1988). Here, we find that the employer exercised control over the details of each

"wrestler's" work. The object of the matches was not to determine athletic prowess, but to entertain the male customers. The employer or another employee was involved in the details of each match and the distribution of any proceeds. The female contestants were required, because they were minors, to wait away from the wrestling area between matches.

Under these circumstances, the Referee found that each female participant was a subject worker. We agree and affirm.

ORDER

The Referee's order dated October 29, 1987 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,300, to be paid by the insurer. A client-paid fee, not to exceed $1,641, is approved.

GEORGE L. HUNT, Claimant
Peter O. Hansen, Claimant's Attorney
Mark Bronstein (SAIF), Defense Attorney
Brian L. Pocock, Defense Attorney

WCB 87-17978
October 30, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Fink's order that dismissed his hearing request as barred by application of the doctrine of res judicata. We affirm on other grounds.

ISSUE

Whether the SAIF Corporation's alleged failure to expeditiously prepare and submit a disputed claim settlement for approval, if proven, gives rise to entitlement to a penalty and associated attorney fee?

FINDINGS OF FACT

On or about October 2, 1987, the parties agreed to settle their disputes in WCB Case No. 87-04530 pursuant to a disputed claim settlement. See ORS 656.289. The settlement agreement was drafted by SAIF's counsel, forwarded to claimant's attorney, submitted to the Hearings Division for approval, and approved by a Referee on December 3, 1987. SAIF paid the sums owing under the agreement on December 16, 1987.

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing seeking penalties and attorney fees. Citing ORS 656.262(10), claimant alleged that the failure of SAIF's counsel to prepare and submit the settlement agreement more expeditiously constituted unreasonable resistance or delay in the payment of compensation.

The Referee concluded that claimant should have raised the issue of unreasonable delay in preparing the settlement agreement prior to approval of the agreement by the Referee on December 3, 1987. Applying res judicata principles, the Referee concluded that claimant's failure to litigate the issue at that time precluded him from doing so now.

We agree that claimant is not entitled to penalties and attorney fees; however, we decide the case on other than res judicata grounds.

As pertinent, ORS 656.262(10) provides:

> "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 plus any attorney fees which may be assessed under ORS 656.382." (Emphasis added).

Claimant alleges entitlement to a penalty and associated attorney fee pursuant to this statute. However, the Court of Appeals has held that payments pursuant to a disputed claim settlement are not "compensation" under the statute. Howard v. Liberty Northwest Insurance, 94 Or App 283 (1988). Accordingly, no statutory authority exists for assessment of a penalty or award of an attorney fee.

ORDER

The Referee's order dated February 8, 1988 is affirmed.

DEBORAH E. KNOX, Claimant — WCB 86-06256 & 86-03057
Judith A. Moore, dba, JUDY'S KITCHEN, Employer — October 30, 1989
Roll, Westmoreland, et al., Claimant's Attorneys — Order on Review
Ray Miller (SAIF), Defense Attorney
Carl M. Davis, Assistant Attorney General

Reviewed by Board Members Howell and Speer.

Judith Moore, an alleged noncomplying employer, requests review of Referee Podnar's order that found that claimant was a subject worker. On review, the alleged employer contends that claimant was not a subject worker.

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

The Director's January 9, 1986 proposed and final order which found the alleged employer to be noncomplying, is prima facie correct. The alleged noncomplying employer has the burden to prove that it was incorrect. ORS 656.740(1).

We find that the alleged employer had the right to and did exercise control over claimant. Furthermore, the employer paid for claimant's services as manager for the restaurant and furnished equipment for those services. In making these findings, we consider it particularly persuasive that claimant made no hiring or firing decisions without permission from the employer and that all business records were in the name of the employer. We further note that the employer took the cash register proceeds for her personal finances and, soon after claimant became manager, the employer raised her hourly wages.

Based on these findings, we conclude that the alleged employer contracted with claimant to pay a remuneration for, and had the right to direct and control the performance of, claimant's services. Accordingly, we agree with the Referee that claimant was a subject worker. See ORS 656.005(13), (27); Woody v. Waibel, 276 Or 189, 196 (1976); Henn v. SAIF, 60 Or App 587, 591, rev den 294 Or 536 (1983).

ORDER

The Referee's order dated September 15, 1987 is affirmed. For services on review, claimant's attorney is awarded $300, to be paid by the SAIF Corporation on behalf of the non complying employer.

KURT C. MILLER, Claimant	WCB 86-13534
John J. Cosgrave, Claimant's Attorney	October 30, 1989
Judy Johnson (SAIF), Defense Attorney	Order on Review
Anne Kelley, Assistant Attorney General	

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Hoguet's order that: (1) awarded 5 percent (16 degrees) unscheduled permanent disability for a left shoulder condition, in addition to 30 percent (96 degrees) previously awarded by a Determination Order, for a total of 35 percent (112 degrees); and (2) declined to award scheduled permanent disability for loss of use or function of the left arm. The SAIF Corporation cross-requests review of that portion of the Referee's order that affirmed the Determination Order finding that claimant was medically stationary on July 25, 1986. The issues on review are the extent of unscheduled permanent disability, the extent of scheduled disability, and temporary total disability. We modify and affirm.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

On October 17, 1985, no further material improvement in claimant's left shoulder condition could reasonably be expected from further medical treatment or the passage of time.

The loss of use or function in claimant's left arm is a result of his 1984 compensable injury and impairment in his left shoulder and neck.

As a result of his 1984 compensable injury, claimant has suffered permanent impairment to his left shoulder and neck in the mild range.

Claimant's permanent left shoulder/neck impairment, when considered with his age, education, and transferable skills, has resulted in 35 percent permanent loss of earning capacity.

CONCLUSIONS OF LAW AND OPINION

On the issues of the extent of unscheduled permanent disability and the extent of scheduled disability, we adopt the Referee's "Conclusions and Opinion" with the following observation. Claimant clearly has less use of his left arm now than before his 1984 injury. We find that reduction in use to be due to permanent impairment in claimant's left shoulder and neck, not in the arm itself. The evidence does not establish any injury related impairment to the arm. Claimant's entire disability is, therefore, considered as unscheduled.

The Referee found that SAIF did not proceed to close the claim after receiving evidence that claimant was medically

stationary on October 17, 1985. Therefore, the Referee concluded that claimant was not medically stationary until July 25, 1986, the date found by the Evaluation Division. We disagree. ORS 656.005(17) defines "medically stationary" as that point in time when no further material improvement can reasonably be expected from medical treatment or the passage of time. We conclude that claimant was medically stationary on October 17, 1985.

The Determination Order of September 18, 1986, found claimant to be medically stationary on July 25, 1986. SAIF disagreed with this finding and raised the issue in a request for hearing. It was SAIF's theory that claimant was medically stationary on October 17, 1985. Therefore, SAIF had the burden of proving claimant was medically stationary prior to the date set forth in the Determination Order. Harris v. SAIF, 292 Or 683 (1982); Norton v. SAIF, 86 Or App 447 (1987).

SAIF relies on the independent medical examination of the Orthopaedic Consultants dated October 17, 1985, which found claimant to be medically stationary. After receiving this report, SAIF forwarded it to Dr. Goss, then believed to be claimant's treating physician. SAIF also received a response from Dr. Paxton, claimant's new treating physician, concurring with the Consultants' report. This response is dated March 11, 1986. Dr. Paxton later opined on July 25, 1986, when he was again claimant's treating physician, that claimant had been medically stationary "long ago."

Claimant briefly changed treating physicians to Dr. Moore, chiropractor, on February 28, 1986. Dr. Moore found him to be not medically stationary. He saw claimant again in March, 1986, and opined claimant was not yet medically stationary.

The Referee did not rely on the reports of Dr. Moore in finding that claimant was not medically stationary prior to July 25, 1986. We agree, since we find his reports to be conclusory and not persuasive. We rely on the reports of Dr. Paxton and the independent medical examination of the Orthopaedic Consultants and conclude that SAIF has proved by a preponderance that claimant was medically stationary on October 17, 1985. Consequently, SAIF may offset temporary total disability paid after that date against claimant's future, if any, awards of permanent disability.

ORDER

The Referee's order dated November 10, 1987, is affirmed in part and modified in part. That portion of the Referee's order that found claimant to be medically stationary on July 25, 1986 is modified. Claimant is determined to be medically stationary as of October 17, 1985. The SAIF Corporation is authorized to offset temporary disability benefits paid between October 17, 1985 and July 25, 1986, against claimant's future, if any, permanent disability awards. The remainder of the Referee's order is affirmed.

DEE G. STEEN, Claimant
Brian R. Whitehead, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-05220
October 30, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Myers' order that upheld the insurer's denial of her occupational disease claim for pain in the upper arm, shoulder and neck, plus headaches. In its brief, the insurer requests review of that portion of the order that assessed an attorney fee for an unreasonable denial. On review, the issues are compensability, penalties, and attorney fees.

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

Compensability

We agree with the Referee that there is no persuasive medical evidence in this record to establish that claimant's work activities were the major contributing cause of her condition or its worsening.

Attorney Fees

The Referee assessed an attorney fee for an unreasonable denial because, at the time the insurer denied the claim, all the available medical evidence indicated claimant's condition was work related. Because there were not amounts then due, a penalty may not be awarded. ORS 656.262(10).

On review, the insurer argues that attorney fees may only be assessed when there is an "amount due." We disagree. ORS 656.262(10) permits assessment of an attorney fee pursuant to ORS 656.382(1) for the unreasonable resistence to the payment of compensation. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989). Thus, ORS 656.382 does not require amounts "then due." Here, however, the claim was not compensable. Claimant has, therefore, not shown that the insurer unreasonably resisted the payment of compensation. Ellis, supra at 78; Cripes, supra. An attorney fee is not assessable.

ORDER

The Referee's order dated November 12, 1987, is affirmed in part and reversed in part. The insurer's March 15, 1987 denial is upheld. The Referee's award of an attorney fee is reversed. A client-paid fee, not to exceed $1,740, is approved.

SUZANNE L. STOREY, Claimant
Brian R. Whitehead, Claimant's Attorney
Kevin L. Mannix, Defense Attorney

WCB 87-10973
October 30, 1989
Order on Review

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Myzak's order that dismissed her hearing request for abandonment. No briefs were filed on Board review. We reverse.

ISSUE

Dismissal. Whether the Referee properly dismissed claimant's hearing request for abandonment.

FINDINGS OF FACT

Claimant filed hearing requests relating to her January 28, 1987, industrial injury in July and August, 1987. On November 17, 1987, the insurer notified claimant by certified mail of an independent medical examination (IME) scheduled for December 5, 1987. Claimant received the notice on November 25, 1987. However, she failed to attend the IME, prompting the insurer to move for dismissal of claimant's hearing request or, alternatively, suspension of the proceedings. Verbally on December 29, 1987, and in writing on December 31, 1987, the Referee ordered suspension of case proceedings until claimant submitted to an IME or for 90 days from December 5, 1987. The Referee also ordered the insurer to schedule another IME by February 5, 1988.

On December 30, 1987, the insurer sent claimant by certified mail notice of an IME scheduled for January 23, 1988. Although the notice was sent to claimant's last known address, there is no indication that she received it. Claimant did not appear for the IME. Shortly thereafter, claimant's attorney advised the insurer that claimant had moved from her previous residence and had not left her forwarding address. The attorney further advised that he had no way of contacting his client. A few days later, claimant's attorney paid the post office in order to obtain his client's forwarding address.

The insurer renewed its motion to dismiss claimant's hearing request for lack of prosecution. On March 15, 1988, the Referee entered an order dismissing claimant's hearing request for abandonment.

FINDING OF ULTIMATE FACT

At the time that the Referee dismissed claimant's hearing request, there was no authority permitting dismissal of a hearing request for abandonment.

CONCLUSIONS OF LAW AND OPINION

The Referee entered the dismissal order in reliance on former OAR 438-06-085, which she stated was "in effect at the time of my Interim Order [dated December 31, 1987,] that suspended proceedings." We hold that the Referee had no authority for dismissing claimant's hearing request under these circumstances.

Former OAR 438-06-085 provided in relevant part that "[a] hearing request may be dismissed for want of prosecution where the party requesting the hearing occasions a delay of more than ninety (90) days without good cause." However, that provision was excluded from Division 06 of OAR 438 that the Board adopted in December, 1987, and that became effective January 1, 1988. See WCB Amin. Order 5-1987. In its stead, the Board adopted former OAR 438-06-071, which applies to all cases that were pending before the Hearings Division on or after January 1, 1988. OAR 438-05-010. This case was pending before the Referee on January 1, 1988. Hence, former OAR 438-06-071 applied.

Former OAR 438-06-071 mandated dismissal of a hearing request if the party requesting the hearing fails to appear for the hearing and if a postponement cannot be granted under OAR 438-06-081. That rule did not authorize a dismissal for "abandonment" or for an unjustified delay of more than 90 days. Indeed, there was no authority under the applicable rules for dismissal under these circumstances. See WCB Admin. Order 5-1987. Accordingly, the hearing request was dismissed in error. See Ring v. Paper Distribution Services, 90 Or App 148 (1988).

We note parenthetically that the current rules permit dismissal of a hearing request if the Referee finds that the party requesting the hearing has abandoned the hearing request or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days. OAR 438-06-071(1).

ORDER

The Referee's dismissal order dated March 15, 1988, as reconsidered on April 13, 1988, is reversed. Claimant's hearing request is reinstated, and the case is remanded to the Referee for further proceedings consistent with this order. The Board approves a client-paid fee not to exceed $300.

HAI N. TRAN, Claimant
Leeroy O. Ehlers, Claimant's Attorney
Bottini, et al., Defense Attorneys

WCB 87-08380
October 30, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of Referee Fink's order that granted permanent total disability, in lieu of 25 percent (80 degrees) unscheduled permanent disability for a cervical condition previously awarded by a Determination Order. The issue on review is the extent of permanent disability, including permanent total disability. We reverse the Referee's order and modify the Determination Order.

FINDINGS OF FACT

Claimant was 57 years of age at hearing. He immigrated to the United States from Vietnam in 1975 and started working for the employer as a band saw operator. He cut wood into component parts for furniture.

In 1984, claimant suffered disabling pain in his neck while working. He continued to work for several months. Dr. Gehling, neurologist, ultimately diagnosed C7 radiculopathy and performed decompression surgery in August, 1984.

Claimant attempted to return to his at-injury position. He was unable to work full days and tried to work half-time. When his pain continued, he was examined by Dr. Mason, neurologist. A myelogram showed a defect at C5-6 and a second decompression surgery was performed in April, 1986.

Claimant moved to California after this operation. He was eligible for vocational rehabilitation in Oregon.

He treated in California with Dr. Magid, neurologist. Because of claimant's continued pain in his neck and problems with his left arm, she recommended another myelogram. Claimant

declined to undergo further surgery. He has not sought work since leaving Oregon other than with his son in California. Claimant could benefit from vocational assistance and is capable of performing some work.

ULTIMATE FINDINGS OF FACT

Claimant is not totally physically incapacitated as a result of his compensable injuries nor is he precluded from regular gainful employment as a result of his injury combined with his age, education, transferable skills and vocational background.

Claimant has not made reasonable efforts to seek work. It would not be futile for him to seek work.

As a result of his compensable injury, claimant has suffered permanent impairment in the moderate range.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, as a result of claimant's compensable injury, combined with his difficulty with the English language, claimant is permanently and totally disabled. We disagree.

We first review the record to determine if claimant is totally physically disabled. We find that he is not. Drs. Gehling, Mason, and Magid all offered opinions as to claimant's permanent disability. None opined that he is completely disabled.

We also consider whether claimant is permanently and totally disabled under the "odd lot" doctrine. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). We consider the factors of age, education, adaptability to other labor, mental condition, and emotional status. If a combination of these factors prove that claimant is permanently incapacitated from regularly performing gainful and suitable employment, we may find him permanently totally disabled.

We are not persuaded that claimant is entitled to permanent total disability under the "odd lot" doctrine.

After his first surgery, Dr. Gehling opined that claimant would suffer some permanent disability. Dr. Mason, who performed the second surgery, opined in September, 1987, that claimant is not permanently totally disabled. Dr. Magid, his treating physician in California, opined in September 1987, that claimant is capable of performing regular work in a sedentary to light position, with no heavy lifting.

Claimant is fluent in Vietnamese and French. He has completed studies in English as a second language. He was a civil servant in Vietnam and has some transferable office skills. A vocational counselor in California reported possible opportunities as an interpreter, office clerk, or courier. Each of these duties would be within claimant's physical restrictions.

An essential element to claimant's case is the "seek work" requirement under ORS 656.206(3). Here, claimant moved to California, resulting in a determination that he was unavailable

for vocational services in Oregon. After de novo review, we are not persuaded that claimant was willing to seek regular employment or that he made reasonable efforts to obtain such employment. See Ibraham G. Trad, 39 Van Natta 346 (1987); James A. Evans, 39 Van Natta 277 (1987).

In this regard, we note that claimant made himself unavailable for vocational rehabilitation services in Oregon, and did not seek work in Oregon, and, after moving to Portland to be with his wife, did not seek work in Oregon. Finally, the record fails to establish that it would have been futile for claimant to have sought employment.

We proceed to rate claimant for unscheduled permanent disability.

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in OAR 438-30-380, et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

The medical evidence indicates claimant is capable of performing sedentary to light work. He has had two surgeries and has difficulty using his left arm. Claimant has difficulty with the English language, but can speak French and Vietnamese. He is restricted from overhead work and from heavy lifting. After reviewing the relevant factors, we conclude that an award of 60 percent unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity.

ORDER

The Referee's order dated November 24, 1987, is reversed. In lieu of the Referee's award of permanent total disability, and in addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by the Determination Order for a cervical injury, claimant is awarded 35 percent (112 degrees) for a total award of 60 percent (192 degrees). Claimant's attorney's fee is adjusted accordingly. A client-paid fee, not to exceed $2,080, is approved.

TERRANCE A. BOSTICK, Claimant	WCB 87-15492
Ralph M. Yenne, Claimant's Attorney	October 31, 1989
Cummins, et al., Defense Attorneys	Order of Dismissal

Claimant has requested review of Referee Higashi's order which dismissed his request for hearing for failing to attend an independent medical examination as directed by a prior Referee's order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS OF FACT

The Referee's Order of Dismissal issued on April 18, 1988.

Pursuant to the order, claimant's hearing request was dismissed "with prejudice" due to his failure to comply with a prior Referee's order to attend an independent medical examination (IME), which was the third IME that claimant had failed to attend. The order contained a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On May 5, 1988, claimant asked the "Hearings Division" to set aside the dismissal order. Claimant submitted his affidavit, setting forth his reasons for not attending prior independent medical examinations. On May 14, 1988, the insurer submitted its response to claimant's motion to set aside the dismissal order. The insurer contended that the dismissal order should stand.

On May 18, 1988, the Referee issued an "Order Denying." The order stated that "[t]he request to set aside the April 18, 1988 Order of Dismissal is DENIED." The May 18, 1988 order neither stayed, abated, modified, or republished the April 18, 1988 order. The May 18, 1988 order contained a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On May 23, 1988, the Board received claimant's request for review of the Referee's May 18, 1988 order. The request, which was mailed by regular mail, included a certificate of personal service by mail stating that the request had been mailed to the insurer's counsel on May 20, 1988.

ULTIMATE FINDINGS OF FACT

Claimant requested Board review within 30 days of the Referee's May 18, 1988 order. However, the Referee's April 18, 1988 Order of Dismissal was neither abated, stayed, republished, modified, nor appealed within 30 days of its issuance.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). 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).

"Filing" means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-05-046(1)(a). If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b).

Here, claimant's request for review, which was mailed by regular mail, was received by the Board on May 23, 1988. Therefore, the request was filed with the Board within 30 days of the Referee's May 18, 1988 order. Yet, the May 18, 1988 order expressly denied claimant's motion to set aside the Referee's

April 18, 1988 dismissal order. Moreover, the May 18, 1988 order neither "stayed" the April 18, 1988 order nor extended the time for seeking review. See International Paper Co. v. Wright, supra, 80 Or App at page 447.

Inasmuch as the 30-day statutory appeal period from the April 18, 1988 order has elapsed without a timely request for review, it has become final by operation of law. See ORS 656.289(3); International Paper Co. v. Wright, supra; Farmers Insurance Group v. SAIF, supra. Furthermore, because the Referee's subsequent order refused to reconsider matters that have become final by operation of law, no issues remain for us to consider. See Floarea Perva, 39 Van Natta 454 (1987).

Accordingly, the request for Board review is dismissed. A client-paid fee, payable by the insurer to its counsel, not to exceed $902, is approved.

IT IS SO ORDERED.

JANET KELLER, Claimant
Vick & Gutzler, Claimant's Attorneys
Randolph Harris (SAIF), Defense Attorney

WCB 88-13993
October 31, 1989
Order on Review

Reviewed by Board Members Nichols and Crider.

Claimant requests, and the SAIF Corporation cross-requests, review of Referee Mills' order that: (1) increased claimant's scheduled permanent disability award for a loss of use or function of the left arm from 9 percent (17.28 degrees), as awarded by Determination Order, to 10 percent (19.2 degrees); and (2) increased claimant's scheduled permanent disability award for a loss of use or function of the right arm from 12 percent (23.04 degrees), as awarded by Determination Order, to 13 percent (24.96 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

As a result of her compensable injury, claimant has sustained a loss of grip strength in her upper extremities. This loss, which is mild, is attributable to ulnar nerve damage below the midforearm and below the elbow, bilaterally.

CONCLUSIONS OF LAW

We adopt the Referee's "Conclusions and Opinion," except that portion which pertained to loss of grip strength.

Concluding that the record did not indicate a basis for claimant's loss of grip strength, the Referee declined to award any permanent disability for such a loss. Inasmuch as we find the loss of grip strength attributable to nerve damage, we find that claimant's awards should be increased.

To receive an award for grip strength loss, claimant must establish that the loss is either due to nerve damage, atrophy, or other anatomical changes. OAR 436-35-110(3)(a), (d). Decreased grip strength due to amputation or loss in range of

motion in the joints of the hand or fingers receive no rating in addition to that given for the amputation or loss of range of motion. OAR 436-35-110(3)(b), (c).

Here, claimant testified that her ability to hold items in either hand had diminished since her compensable injury. This loss of grip strength was supported by objective findings submitted by Dr. Hermens, claimant's treating surgeon, Dr. Button, a consulting surgeon, and Dr. Mizrahi, a consulting chiropractor.

No amputation was performed. The medical findings further suggest that claimant did not experience a loss in range of motion in the joints of her hands or fingers. Finally, the record indicates that there was no atrophy or other anatomical change in claimant's upper extremities. Instead, objective testing confirms that claimant was experiencing mild symptoms suggestive of ulnar nerve irritability.

In reaching this conclusion, we rely upon the findings and opinions offered by Dr. Berkeley, consulting neurosurgeon, and Dr. Long, consulting neurologist. These physicians found bilateral symptoms, which were indicative of ulnar nerve lesions or entrapments in the proximal forearm and elbow areas. These findings were further confirmed by Dr. Hermens, who attributed claimant's neurological deficiencies to a bilateral ulnar problem. Even Dr. Button, a surgeon who disagreed with Dr. Berkeley's proposal for future surgery, noted low grip strength measurements and the existence of mild symptoms suggestive of ulnar nerve irritability.

The aforementioned evidence leads us to the conclusion that claimant has sustained a loss of grip strength due to ulnar nerve damage (below midforearm and below elbow), which is attributable to her compensable bilateral upper extremity condition and subsequent surgeries. We further conclude that this loss of grip strength has resulted in a mild loss of function. See OAR 436-35-110(3)(a). Inasmuch as the maximum loss of function due to loss of strength in the ulnar nerve (below midforearm and below elbow) is 28 percent, we find that a 5 percent value for each forearm provides appropriate compensation for such a loss.

These additional values are combined with claimant's forearm ratings, as previously found by the Referee, of 7 percent for each of claimant's forearms. This combination totals 12 percent for each forearm, which converts to 9 percent of each arm. OAR 436-35-090(1).

We agree with the Referee that claimant is entitled to a 5 percent value for the loss of flexion and extension in her left elbow and an 8 percent value for the loss of flexion and extension in her right elbow. When the aforementioned 9 percent "forearm to arm conversion" values are combined with these "elbow" figures the following totals are reached. For the left arm, a combination of 9 percent and 5 percent equals 14 percent, which we conclude appropriately compensates claimant for the loss of use or function of the left arm. Turning to the right arm, a combination of 9 percent and 8 percent equals 16 percent, which we also conclude provides adequate compensation for the loss of use or function of claimant's right arm.

ORDER

The Referee's order dated December 5, 1988 is modified. In addition to the 10 percent (19.2 degrees) scheduled permanent disability award for loss of use or function of the left arm, as previously granted by the Determination Order and Referee's order, claimant is awarded 4 percent (7.68 degrees) scheduled permanent disability, for a total award to date of 14 percent (26.88 degrees). In addition to the 13 percent (24.96 degrees) scheduled permanent disability award for loss of use or function of the right arm, as previously granted by the Determination Order and Referee's order, claimant is awarded 3 percent (5.76 degrees), for a total award to date of 16 percent (30.72 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, but the total fees approved by the Referee and the Board shall not exceed $3,800.

THOMAS L. LINGO, Claimant
Malagon & Moore, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-04232
October 31, 1989
Order on Reconsideration

Claimant requests reconsideration of our October 10, 1989 Order on Review that affirmed a Referee's order which: (1) upheld the insurer's partial denial of claimant's medical services claim for current dental care; (2) upheld the insurer's denial of claimant's aggravation claim for his left shoulder condition; (3) upheld the insurer's partial denial of claimant's medical services claim for chiropractic care; and (4) upheld the insurer's partial denial of claimant's psychological treatments. Specifically, claimant asserts that Board member Gerner should not have considered this case because he represented claimant concerning a 1983 injury claim. In addition, claimant seeks permission to submit a supplemental brief.

We address claimant's latter contention first. Claimant, through his current attorneys of record, has previously submitted an appellant's and a reply brief. See OAR 438-11-020(2). Inasmuch as claimant has already fully availed himself of his opportunity to file written arguments in this matter, his request to submit an additional brief is denied.

Finally, claimant's first contention has been rendered moot by Board member Cushing's participation in this case. After having reviewed the entire record and the parties' arguments, Member Cushing is in agreement with all of the findings and conclusions reached in the Board's prior order.

Consequently, our October 10, 1989 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 10, 1989 order, in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

GEORGE V. LYNESS, Claimant
Francesconi & Associates, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
James E. Griffin, Assistant Attorney General

WCB TP-89018
October 31, 1989
Third Party Distribution Order

The SAIF Corporation, as paying agency, has petitioned the Board for resolution of a dispute concerning the "just and proper" distribution of proceeds from claimant's third party settlement. See ORS 656.593(3). We conclude that SAIF is entitled to a share of the settlement proceeds and that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS

In October 1984, claimant sustained injuries to his neck, upper back and right shoulder, while working as a welder and iron worker. SAIF has accepted and processed the claim.

In September 1986, a Determination Order awarded 30 percent unscheduled permanent disability. Claimant requested a hearing, seeking an additional award, including permanent total disability.

Claimant also initiated a third party action, stemming from his compensable injury. He and the third party agreed to settle the action for $81,500. Thereafter, claimant and SAIF entered into negotiations designed to resolve the pending hearing request and, potentially, the third party settlement.

The aforementioned negotiations resulted in a March 1988 stipulation. Pursuant to the agreement, claimant received an additional 60 percent unscheduled permanent disability award. A provision which stated "[c]laimant stipulates that he has retired and voluntarily withdrawn from the labor force" was deleted from the agreement by interlineation.

The stipulation concerning the hearing request neither mentioned the proposed third party settlement nor SAIF's lien as a paying agency. SAIF approved the third party settlement, but has not received a portion of the settlement proceeds.

To date, SAIF has incurred actual claim costs totalling $104,218.64. These costs are comprised of $23,451.46 in medical expenses, $51,967.18 in time loss, and $28,800 in permanent disability benefits.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third person, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS56.593(1).

"Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576. "Insurer" means SAIF or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state. ORS 656.005(14).

If the worker or beneficiaries settle the third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper", provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavill, 39 Van Natta 721 (1987). ORS 656.593(1) provides in exact detail how, and in what a order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs 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. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, claimant sustained a compensable injury for which SAIF has accepted responsibility. Inasmuch as SAIF has paid benefits to claimant as a result of the compensable injury, it is a "paying agency." See ORS 656.005(14); 656.576.

Furthermore, upon claimant's election to seek the recovery of damages against the third party, the provisions of ORS 656.593 became applicable. Thus, SAIF is entitled to its statutory share of proceeds from the third party settlement recovered by claimant. See ORS 656.593(3).

Claimant's attorney asserts that he "would not have agreed to settle [claimant's hearing request] short of permanent total disability except for the consideration of not having to return the lien and [he] never advised SAIF Corporation otherwise." Thus, should we conclude that SAIF is entitled to a portion of the settlement, claimant's counsel contends that the stipulation should be vacated.

The stipulation to which claimant is referring resolved claimant's hearing request from a Determination Order. As such, it was a matter "concerning a claim." See ORS 656.283(1). Therefore, should a party contend that rescission of a previously approved stipulation is required, the appropriate avenue to resolve this "question concerning a claim" would be the Hearings Division.

Our authority concerning this dispute is strictly limited to a determination of whether SAIF, as a paying agency, is entitled to a share of the third party settlement. If that question is answered in the affirmative, we then turn to the issue of what constitutes a "just and proper" distribution of the settlement proceeds. See ORS 656.593(3).

Considering claimant's assertions, we interpret his position to be that SAIF is not entitled to a share of the settlement proceeds; i.e., a distribution of the settlement proceeds in a manner in which SAIF recovers nothing would be "just and proper." We disagree.

As previously noted, we generally apply the statutory formula for distribution of a third party judgment, ORS 656.593(1), to the distribution of proceeds from a third party settlement. We take such an approach to avoid making "equitable distributions on an ad hoc basis" and to permit the parties to generally know where they stand as they seek to settle a third party action. See Marvin Thornton, 34 Van Natta 999, 1002 (1982). On rare occasions, circumstances may justify a departure from the statutory distribution formula. See Robert T. Gerlach, 36 Van Natta 293, 296 (1984). (Paying agency's lien reduced to "in effect, reconstruct an agreement the parties substantially entered into, but which subsequently fell apart primarily due to an unfortunate failure of communication.")

Here, neither the stipulation nor any other document submitted to us, mentions either a third party settlement or a waiver of SAIF's third party lien.

These circumstances lead us to conclude that, although SAIF initially offered to waive its third party lien, the condition precedent to that waiver was never accomplished; i.e., claimant did not stipulate that he had retired and had voluntarily withdrawn from the work force. In other words, the record does not establish that the parties reached am agreement that SAIF would waive its third party lien or that SAIF would have done so but for a failure of communication. Consequently, we decline to depart from our general approach to distribute third party settlement proceeds in accordance with ORS 656.593(1).

Finally, SAIF has established that it has incurred actual claim costs currently totalling $104,218.64. Therefore, it is entitled to recover such costs to the extent possible, from the balance of settlement proceeds which should have remained after claimant's attorney fee, litigation costs, and statutory 1/3 share were distributed. See ORS 656.593(1)(a), (b), and (c).

For illustrative purposes, assuming that claimant incurred no litigation costs, the proceeds should have been distributed as follows:

Settlement Proceeds:	$81,500.00
Attorney Fee (1/3)	27,166.67
Subtotal	54,333.33
Claimant's 1/3 share	18,111.11
Remaining Balance	$36,222.22

Accordingly, we hold that a distribution of the third party settlement proceeds in accordance with ORS 656.593(1) is "just and proper." See ORS 656.593(3). Consequently, after the distribution of claimant's attorney fee, litigation costs, and statutory 1/3 share, claimant is directed to pay to SAIF the remaining balance of the settlement proceeds. See ORS 656.593(1)(c).

IT IS SO ORDERED.

RODNEY K. MILLER, Claimant
Burt, et al., Claimant's Attorneys
G. Howard Cliff, Defense Attorney

WCB 86-15368
October 31, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

The insurer requests review of Referee Michael Johnson's order which found that claimant's low back injury claim had been prematurely closed by an October 1986 Determination Order. Should we find that the claim was not prematurely closed, the insurer further requests that we affirm the Determination Order that awarded 15 percent (48 degrees) unscheduled permanent partial disability. On review, the issues are premature closure and extent of permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" beginning on page 2 and ending with the first sentence on the top of page 3 with the following supplementation.

As a result of his compensable injury, claimant has permanent impairment in the mild range.

FINDINGS OF ULTIMATE FACT

On October 24, 1986, the date of the Determination Order, claimant's compensable condition had reached the point where no further material improvement would reasonably be expected from medical treatment or the passage of time.

As a result of his compensable injury, claimant has sustained a loss of earning capacity equal to 25 percent.

CONCLUSIONS OF LAW

Premature Claim Closure

The Referee concluded that claimant was not medically stationary as of August 21, 1986. We disagree.

In order to establish that the Determination Order, which issued October 24, 1986, prematurely closed his claim, claimant must demonstrate that he was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625 (1987). "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17).

The Orthopaedic Consultants examined claimant in August 1986. At that time, the Consultants opined that claimant was medically stationary with minimal permanent impairment. The Consultants examined claimant again in May 1987 and reported no change in his condition since their August 1986 examination.

Conversely, Dr. Schmidt, claimant's treating chiropractor, reported in October 1986 that claimant was improving and therefore not medically stationary. In November 1986, Schmidt again reported that claimant's condition was improving. In March 1987, Schmidt reported that claimant's condition continued to improve and felt the condition was not stationary.

Claimant credibly testified that his condition had not changed since August 1986.

We conclude that claimant has not established that his claim was prematurely closed. In reaching this conclusion, we rely on the opinion of the Orthopaedic Consultants and claimant's credible testimony that his condition has remained unchanged since August 1986. We are not persuaded by Dr. Schmidt's conclusory statements that claimant was not stationary because he was improving, as claimant testified that his condition remained unchanged. Accordingly, we find that claimant was medically stationary on August 21, 1986.

Unscheduled Permanent Disability

The Referee found the extent of permanent disability issue to be moot as he had concluded that the claim was prematurely closed. As we have reversed him on that issue, we proceed to rate the extent of claimant's unscheduled permanent disability.

In rating the extent of claimant's disability, we consider his permanent physical impairment, in light of lay testimony concerning his disabling pain and all relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

The Referee found in the alternative that had the claim not been prematurely closed, he would have awarded 25 percent unscheduled permanent disability. After considering the aforementioned guidelines, we agree with the Referee that claimant is entitled to a 25 percent unscheduled permanent disability award for his low back injury. In making this finding, we rely on the fact that claimant: can no longer perform heavy work including some facets of farm work; is limited in his ability to sit, stoop and bend; and suffers chronic pain in the buttocks and hip.

ORDER

The Referee's order dated September 14, 1987 is reversed. The October 24, 1986 Determination Order is reinstated and upheld insofar as it pertains to claimant's medically stationary date. In addition to the Determination Order award of 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees), for a total to date of 25 percent (80 degrees) unscheduled permanent disability for a low back injury. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed a total of $3,800 in attorney fees for the hearing and Board levels.

DELLA A. MONZON, Claimant	WCB 86-17636
Haugh & Foote, Claimant's Attorneys	October 31, 1989
Cummins, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Crider and Nichols.

The insurer requests review of those portions of Referee Tuhy's order which: (1) awarded claimant 25 percent (37.5 degrees) scheduled permanent partial disability for loss of use of her right forearm (wrist), whereas a Determination Order had awarded no

permanent disability; and (2) declined to authorize an offset of temporary disability benefits, which the Referee found had been paid on a gratuitous basis. Claimant cross-requests review of those portions of the order which declined to assess penalties and related attorney fees for an alleged late payment of compensation. Claimant further contends that she is entitled to temporary disability benefits from November 12, 1985, through February 2, 1987. On review, the issues are extent of permanent disability, offset, penalties and related attorney fees and temporary disability benefits. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant was employed as an "on site" cook for the employer. In September 1985, claimant carried a fifty pound sack of potatoes and, when setting them down, felt a burning type of pain in the right hand and arm. She returned to work the day of the injury. Claimant first sought treatment in October 1985 from Dr. Gerow, M. D., who diagnosed a stretch injury of the right trapezius and right carpal tunnel syndrome. On November 12, 1985, Dr. Gerow recommended that claimant refrain from working until further notice.

In November 1985, claimant was also examined by Dr. Smith, neurosurgeon. Dr. Smith reported that claimant had clinical evidence of median nerve entrapment at the right wrist for which he recommended surgery. On January 9, 1986, the insurer expressly accepted claimant's "stretch injury of the right arm (shoulder)." The insurer, however, denied claimant's carpal tunnel syndrome.

In January 1986, Dr. Gerow reported that claimant's stretch injury had resolved. In March 1986, a Determination Order issued, which awarded claimant temporary total disability benefits from November 12, 1985 through January 8, 1986. The Determination Order did not award any permanent disability and noted that it was not a determination of any conditions denied by the insurer's letter dated January 9, 1986.

In October 1986, the parties entered into a stipulation by which the insurer reiterated its acceptance of claimant's musculotendinitis strain to the right upper extremity. The insurer also acknowledged that the accepted injury resulted in symptomatic increases of the right carpal tunnel condition necessitating medical treatment up to and including surgery. The stipulation provided that to the extent that the injury increased the symptomatology of the preexisting right carpal tunnel condition, the insurer accepted responsibility for treatment of those symptoms. The agreement further provided that the underlying carpal tunnel condition was not work-related and that the prior denial would be affirmed insofar as it related to the underlying carpal tunnel condition. The stipulation was approved by a Referee on October 23, 1986.

On December 8, 1986, claimant underwent right carpal tunnel release surgery, performed by Dr. Smith. On February 2, 1987, Dr. Smith reported that claimant was recovering nicely from her surgery and dismissed her from his care. Following this, the insurer submitted the claim for closure, as an original injury, noting on the 1502 form that temporary disability benefits had been paid from November 12, 1985 through February 5, 1987. In July

1987, a second Determination Order issued which awarded temporary disability benefits from December 8, 1986 through February 2, 1987. No permanent disability was awarded.

Prior to the issuance of the July 1987 Determination Order, the insurer paid temporary disability benefits from September 24, 1986 through December 7, 1986. The check covering September 24, 1986 through November 13, 1986, was issued December 9, 1986. The check covering November 14, 1986 through November 27, 1986, was issued on December 19, 1986. The check covering November 28, 1986 through December 7, 1986 was issued January 1, 1987.

In the spring of 1987, claimant went to work as an assistant cook for Washington County. She favored her right hand and still experienced pain in that hand. In July 1987, claimant was examined by Dr. Reimer, neurologist. At that time, studies revealed tenderness over the right distal wrist area. Dr. Reimer noted that claimant's sensory latency was still delayed at the wrist, but better than it was prior to her surgery. Conduction velocity from the elbow to wrist was slowed, suggesting a median nerve neuropathy which claimant did not have prior to the surgery. Dr. Reimer did not feel that claimant was a candidate for further treatment, other than conservative management with the use of oral anti-inflammatories.

Claimant is right-handed and experienced no symptomatology referable to either hand or wrist prior to the compensable injury. She has difficulty gripping objects and experiences pain which sometimes awakens her at night. She also experiences cramps while gripping objects, but they subside after a few minutes.

FINDINGS OF ULTIMATE FACT

As a result of her compensable carpal tunnel symptoms, claimant has suffered a 25 percent permanent loss of use or function of her right forearm.

Claimant was unable to perform work activities as a result of her compensable right wrist and shoulder condition from November 12, 1985 through February 2, 1987.

The insurer unreasonably failed to pay claimant temporary disability benefits for the period between November 14, 1986 and November 27, 1986 within 14 days.

CONCLUSIONS OF LAW

At the outset, the employer submits that claimant is not entitled to any permanent disability or temporary disability benefits, above that awarded by Determination Order, as all her symptoms are related to her carpal tunnel condition. The employer contends that the October 1986 stipulation precludes claimant from all benefits, with the exception of medical services, for her right carpal tunnel symptoms. We disagree.

The stipulation expressly accepts claimant's right carpal tunnel symptomatology, while denying the underlying carpal tunnel condition. By accepting claimant's carpal tunnel symptoms, the insurer has accepted responsibility for all benefits flowing from

that acceptance. To interpret the stipulation to provide only for payment of medical services for the accepted carpal tunnel symptoms would render it invalid. See ORS 656.236(1). Therefore, we conclude that the employer has accepted claimant's right carpal tunnel symptomatology and is responsible for all benefits, including temporary and permanent disability, that stem from the accepted claim.

SCHEDULED PERMANENT PARTIAL DISABILITY

Based on the medical and lay evidence, including claimant's credible testimony, the Referee found that claimant had permanently lost the use or function of her right forearm, equal to 25 percent, as a result of her compensable injury. We agree.

As a preliminary matter, we note that there is no medical or lay evidence suggesting that claimant has sustained permanent impairment as a result of her right shoulder strain. Therefore, if claimant is entitled to any permanent disability, such disability would be rated on permanent impairment resulting from her compensable right carpal tunnel symptoms. Barrett v. D & H Drywall, 300 Or 325, on recon 300 Or 553 (1985).

Extent of scheduled permanent disability is measured by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining loss of use or function, we consider the medical and lay evidence in light of the rules set forth in OAR 436-30-001 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See SAIF v. Baer, 61 Or App 335, 337-38 rev den 294 Or 749 (1983); Isabel Aparicio, 38 Van Natta 421-22 (1986). Loss of use or function does not necessarily correlate with the mechanical impairment, although mechanical impairment is usually an important consideration. Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980).

Following surgery, Dr. Reimer reported that claimant's sensory latency was still delayed at the right wrist. He further reported conduction velocity from the elbow to the wrist was slowed. Claimant credibly testified that she has difficulty gripping objects and experiences pain which sometimes awakens her at night. She also experiences cramps while gripping objects, but they subside after a few minutes.

After considering the aforementioned guidelines, and taking into account the medical evidence as well as claimant's credible testimony concerning her disabling pain and physical limitations, we conclude that a 25 percent scheduled permanent partial disability award for loss of use or function of the right forearm (wrist) appropriately compensates claimant.

TEMPORARY DISABILITY BENEFITS

As we have found that the insurer accepted claimant's right carpal tunnel symptomatology, it is necessary to address what temporary disability benefits are related to this accepted condition. Prior Determination Orders have awarded claimant temporary disability benefits from November 12, 1985 through January 8, 1986, as well as from December 8, 1986 through February 2, 1987. In addition to paying these benefits, the insurer paid temporary disability benefits from September 24, 1986 through December 7, 1986. Therefore, the issue becomes claimant's

entitlement to temporary disability benefits from January 9, 1986 through September 23, 1986. The Referee did not award temporary disability benefits for this period. We disagree.

Claimant was released from work by Dr. Gerow on November 12, 1985. She was found to be medically stationary and released to work by Dr. Smith on February 2, 1987, following the right carpal tunnel release procedure. There is no release to work in the record prior to February 2, 1987. Further, claimant credibly testified that she was unable to work during this time period, with the exception of some part-time work during the Spring of 1986, when she attempted to return to work. Accordingly, claimant is entitled to temporary disability benefits, as a result of her compensable right shoulder strain and right carpal tunnel symptoms, during this time period. We note, however, that claimant did return to part-time work during the spring of 1986. Therefore, claimant is entitled to temporary disability benefits, from January 9, 1986 through September 23, 1986, less time worked during that period.

In reaching this conclusion, we note that our interpretation of the October 1986 stipulation necessarily renders the March 1986 Determination Order void. This conclusion is supported by the insurer's subsequent conduct in submitting the claim for closure as an original injury rather than an aggravation in May 1987. As the stipulation accepted claimant's carpal tunnel symptoms as part of the original compensable claim, and that condition was not stationary at the time of closure, the agreement has the effect of making the March 1986 Determination Order premature and thus void. Under these circumstances, claimant is entitled to the temporary disability benefits noted above.

OFFSET

As we have found that claimant is entitled to temporary disability benefits from November 12, 1985, through February 2, 1987, there is no basis for the insurer's requested offset for time loss paid from September 24, 1986 through December 7, 1986.

PENALTIES AND ATTORNEY FEES

Claimant contends that the insurer's late payment of temporary disability benefits for the period of November 14, 1986 through November 27, 1986 was unreasonable. We agree.

Following the October 1986 stipulation, the insurer paid temporary disability benefits for a period beginning September 24, 1986 and ending December 7, 1986. On December 9, 1986, the insurer issued a check covering temporary disability benefits from September 24, 1986 through November 13, 1986. However, the insurer waited until December 19, 1986 to issue a check covering November 14, 1986 through November 27, 1986.

The insurer offers no explanation as to why the check for November 14, 1986 through November 27, 1986 was delayed 10 days when, in fact, the check should have issued on December 9, 1986. Under these circumstances, we conclude that a 25 percent penalty and a reasonable attorney fee are warranted. See Arlene Marshall, 40 Van Natta 1828-29 (1988).

ORDER

The Referee's order dated September 18, 1987 is affirmed in part and modified in part. In addition to the temporary disability awarded by the Determination Order, and that previously paid by the insurer, claimant is awarded temporary disability benefits, less time worked, from January 9, 1986 through September 23, 1986. Claimant's attorney is awarded 25 percent of the increased compensation created by this order; however, the total fees awarded by the Referee and the Board orders shall not exceed $3,800. Claimant is further awarded a penalty equal to 25 percent of the time loss paid from November 14, 1986 through November 27, 1986. Claimant's attorney is awarded a reasonable assessed fee of $500, for services at hearing and Board review for prevailing on the penalty issue. The remainder of the order is affirmed. For services on review regarding the scheduled permanent disability and offset issue, claimant's counsel is awarded a reasonable assessed fee of $500. A client-paid fee, not to exceed $510.50, is approved.

CLEMENTE PORRAS, Claimant	WCB 87-06305
Brian R. Whitehead, Claimant's Attorney	October 31, 1989
Garrett, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Nichols and Brittingham.

The self-insured employer requests review of Referee Myzak's order that set aside its denial of chiropractic and acupuncture treatments and assessed a penalty and associated attorney fee for unreasonable denial of chiropractic treatments and for failure to pay for acupuncture treatments pursuant to the terms of a stipulated agreement. We affirm in part and reverse in part.

ISSUES

1. Compensability of palliative chiropractic treatments.

2. Compensability of acupuncture treatments.

3. Penalty and attorney fees.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We find the following additional facts. The chiropractic treatments claimant received provided relief from pain for several hours up to several days, depending upon the level of his activity. Claimant has continued to work as a mushroom picker but is less productive than he was before his injury.

CONCLUSIONS AND OPINION

1. Chiropractic Treatment.

The Referee found that the terms of the January 12, 1987 settlement agreement bound the employer to pay for claimant's first four chiropractic treatments every month, reasoning that the employer had stipulated away its right to contest whether those treatments are palliative. We disagree with the Referee's conclusion. We agree that the employer agreed to pay for palliative chiropractic treatments under the medical guidelines established by the Director. That, however, should not bar the

employer from contesting payment for treatments that it believes are not palliative.

On the merits, we conclude that claimant's testimony and that of his attending chiropractor that the chiropractic treatments aid claimant's ability to continue working outweigh Dr. Howell's opinion that the treatments are "potentially harmful." (Ex. 43-7.) We conclude that claimant has established by a preponderance of the evidence that the treatments are palliative, and we affirm the Referee's conclusion that the denial should be set aside as to chiropractic treatments.

2. Acupuncture.

The employer based its denial of acupuncture on its interpretation of OAR 436-10-040(4) (WCD Admin. Order 6-1985), which provides in relevant part:

> "(a) Physical therapy, biofeedback or acupuncture shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment and which must be completed and signed by the attending physician within one week of the beginning of treatment. The treatment plan shall include objectives, modalities, and frequency of treatment. A copy of the progress notes shall be provided insurer upon request.
>
> "The initial treatment plan shall be for no more than 20 therapy visits in the first 60 days. If more than 20 therapy visits are required in the first 60 days or more than four therapy visits a month after the first 60 days, the physician shall submit a report documenting the need for services in excess of the guidelines upon request of the insurer."
>
> "(b) A judgment by the insurer that the report does not justify treatment in excess of the guidelines shall promptly be communicated to the physician and the therapist. The physician may appeal to the medical director who may rule in favor of the physician, the insurer, or refer the matter to a peer review committee."

The Referee concluded that claimant's attending physician substantially complied with the regulation, but she did not clearly articulate her reasoning. We agree with the Referee's conclusion, for the following reasons. Dr. Whitmire's October 15, 1986 letter states in relevant part:

> "I would like to refer [claimant] to Dr. [sic] Gene Bruno for acupuncture treatment of the left shoulder region and mid back.
>
> "I believe that a certified acupuncturist could provide a different treatment method

than what we have been administering, and that this treatment could prove beneficial in furthering his progress.

"We will continue to utilize chiropractic treatment of the spine in conjunction with the acupuncture treatment to promote healing of the spinal tissues. I believe both avenues of treatment are necessary at this time in order to achieve the maximum improvement possible."

The referral to acupuncture is unquestionably written, it is obvious that the modality is acupuncture and the objective is clearly stated. The letter preceded the first acupuncture session by one week. Although the frequency of treatment is not clearly stated, Ex. 45A-8 establishes that there were only 10 treatments in the first 60 days and thereafter treatments were at weekly intervals. On February 20, 1987, Dr. Butler, associated with Dr. Whitmire in treating claimant, clarified that he had not referred claimant for any treatment in excess of the guidelines. There is no evidence that the employer ever requested progress reports. On April 1, 1987, Mr. Bruno, the acupuncturist, provided a report that we conclude literally complies with the regulation. The employer did not issue its denial until May 19, 1987.

We conclude that there was substantial compliance with OAR 436-10-040(4), and that a preponderance of the evidence establishes that the acupuncture treatments were reasonably and necessarily related to claimant's injury. ORS 656.245(1). There is no evidence relevant to a position that the acupuncture was not reasonable and necessary. We affirm the Referee's conclusion that the denial of acupuncture treatments be set aside.

3. Penalty and Attorney Fees.

The Referee based the penalties on her conclusion that the denial of chiropractic treatments was unreasonable, and that the employer unreasonably failed to pay for acupuncture treatments under the terms of the January 12, 1987 stipulation. The Referee's conclusion that the denial of chiropractic treatments was unreasonable was based upon her conclusion that the employer was barred from challenging whether the treatments were, in fact, palliative, which we have rejected. We conclude that the denial of chiropractic treatments was not unreasonable, as it was supported by Dr. Howell's opinion. We further conclude that the January 12, 1987 stipulation provided only for payment of one acupuncture treatment and that payment was made on January 27, 1987. The Referee specifically found that the denial of acupuncture treatments was not unreasonable, but she assessed a penalty on all acupuncture billings unpaid as of the hearing. We adopt the Referee's conclusion that the denial of acupuncture was not unreasonable. We further conclude that the employer fulfilled all of its obligations under the January 12, 1987 stipulation timely. There is no unreasonable conduct to be penalized. That portion of the Referee's order that assessed penalties and associated attorney fees is reversed.

ORDER

The Referee's order dated November 6, 1987 is affirmed

in part and reversed in part. That portion of the Referee's order that assessed penalties and an associated attorney fee of $600 is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded a reasonable assessed attorney fee of $300 for services on Board review concerning the compensability issues, to be paid by the employer. The employer's attorney is authorized a client paid attorney fee not to exceed $1,060.

CHARLES H. WHIDDON, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Mark P. Bronstein (SAIF), Defense Attorney
Williams, et al., Defense Attorneys

WCB 85-14106 & 85-14081
October 31, 1989
Order on Remand

Reviewed by Board Members Crider and Nichols.

This matter is before the Board on remand from the Court of Appeals. United Foam Corp. v. Whiddon, 96 Or App 178 (1989). The court determined that claimant's hearing request concerning the self-insured employer's denial of his aggravation claim was not timely. We have been directed to determine whether claimant had good cause for filing a late request for hearing.

FINDINGS OF FACT

On August 29, 1985, the employer denied claimant's aggravation claim for a low back condition. The denial was sent by certified mail to claimant's correct address. Notices were left at claimant's address on August 31, 1985 and September 5, 1985. Claimant never received those notices from the post office. The certified letter was returned, unclaimed, on September 15, 1985. The employer remailed the denial by regular mail on November 7, 1985. Claimant received that notice and filed his request for hearing on November 14, 1985.

FINDING OF ULTIMATE FACT

Claimant had good cause for filing a late request for hearing.

CONCLUSIONS OF LAW AND OPINION

The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, 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). The determination as to what is good cause for filing a late request is a decision for the Board to make. See Brown v. EBI Companies, 289 Or 455, 460 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

In James G. Adams, 41 Van Natta 1234 (1989), the Board found, under similar facts, that claimant had not received notice of a denial until he had received a second denial letter that was mailed by regular mail. Under such circumstances, we determined that claimant had established good cause for a delay in filing his hearing request. Here, as in Adams, we are persuaded that claimant had good cause for his untimely hearing request. Consequently, we conclude that the hearing request is not barred. See ORS 656.319(1)(b).

Accordingly, as supplemented, we adhere to and republish our order dated May 19, 1987, as reconsidered September 24, 1987.

JOYCE L. HOLLOWAY, Claimant
Ormsbee & Corrigall, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-10017
November 1, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) set aside its denial of claimant's aggravation claim relating to her neck; (2) set aside its denial of medical services relating to her neck; and (3) assessed an attorney fee for its alleged failure to timely disclose certain medical reports. The employer also contends that the Referee erred in excluding a number of exhibits. The issues are evidence, aggravation, medical services and attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable neck injury on July 7, 1986. Her claim was closed by Determination Order dated June 19, 1987 awarding no permanent disability. Claimant continued to work at her regular job at the time of claim closure.

On June 30, 1987, claimant requested a hearing, alleging entitlement to an award of permanent disability. The hearing request included a request for copies "of all present and future medical documents and other information pertaining to this claim." A copy of the hearing request and application to schedule was sent to the employer's counsel.

Claimant left her employment in September 1987 as a result of a worsening of her compensable condition. She had not returned to work as of the date of hearing.

Also in September 1987, claimant underwent a myelogram which disclosed cervical spondylosis at C5-6 and C6-7. Dr. Campagna subsequently requested authorization from the employer to perform surgery.

On September 16, 1987, claimant filed a Supplemental Request for Hearing raising aggravation, premature claim closure, medical services, and penalties and attorney fees for failure to provide updated medical reports as additional issues.

Two days later, on September 18, the Presiding Referee issued a Show Cause Order directed to the employer involving the employer's failure to produce medical reports and other documents as required by administrative rule.

By letter dated October 1, 1987, claimant's counsel advised the Board that he had independently obtained the medical reports which were the subject of the Show Cause Order. Counsel noted that penalties for failure to provide medical reports continued to be an issue for hearing.

Hearing was scheduled for December 21, 1987. On December 7, 1987, the employer's counsel prepared for submission exhibits 1 through 40. Through the inadvertence of an employee of counsel, neither the exhibits nor the index were sent to the Board at this time.

On December 16, 1987, a supplemental index of exhibits was prepared by the employer's counsel. Both the December 7 and December 16 exhibit packets were mailed to the Board on December 17, 1987 and received on December 18, 1987.

Hearing was held as scheduled on December 21, 1987. At hearing, claimant's counsel objected to the admission of the exhibit packets submitted by the employer on the grounds of untimeliness.

The Referee initially deferred ruling on the question, then subsequently sustained the objection and declined to admit most of the exhibits. The only exhibits admitted were those submitted solely for impeachment purposes, as well as those which duplicated exhibits previously submitted by claimant's counsel.

FINDINGS OF ULTIMATE FACT

Claimant's compensable neck condition worsened subsequent to the June 19, 1987 Determination Order. As a result of this worsening, claimant became disabled from work. Moreover, she now requires surgery. This surgery is reasonable and necessary as it relates to her compensable 1986 injury.

The employer did not establish "good cause" for its failure to timely submit its exhibits.

The employer's failure to provide continuing medical reports to claimant until after the September 1987 Show Cause Order amounts to an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

The employer argues that the Referee improperly refused to admit its preferred exhibits into the record. The employer argues in this regard that the Referee failed to consider the fact that claimant was neither surprised nor prejudiced by the late submission of the exhibits. Moreover, the employer contends that "good cause" for its failure to timely submit the exhibits was established.

The applicable administrative rule is former OAR 438-07-005. The rule requires that the employer/insurer file with the assigned referee all documents upon which the insurer intends to rely "[n]ot less than twenty (20) days before the hearing date." Former OAR 438-07-005(3)(a). The rule also provides for the admission of additional evidence in the discretion of the Referee. Former OAR 438-07-005(4).

The employer argues that the Referee improperly failed to consider the question of surprise and prejudice in exercising his discretion. However, the version of OAR 438-07-005(4) in effect in December 1987 did not require consideration of the factors of surprise and prejudice. Instead, the applicable rule provided:

> "At the hearing the referee may in his or her discretion allow admission of additional medical reports or other

documentary evidence not filed as required *** above. In exercising this discretion, the referee shall determine if good cause has been shown for failure to file within the prescribed time limits." Former OAR 438-07-005(4).

A reference to "surprise" and "prejudice" contained in a prior version of the rule was deleted from the rule in effect in December 1987. Therefore, the Referee did not violate the applicable rule by not taking the factors of surprise and prejudice into consideration in deciding to exclude the employer's exhibits.

Further, we do not agree that the employer has established good cause for its untimely submission. The employer's argument is that the failure to timely submit the exhibits resulted from the negligence of one of his employees, who apparently failed to mail the first exhibit packet to the Board until ten days following their preparation for mailing by counsel. The employer cites Brown v. EBI Companies, 289 Or 455, rev den 289 Or 905 (1980) for the proposition that "negligence in the chain of communication" in a law office constitutes "good cause." Claimant argues that the employer's interpretation of Brown is overbroad.

We need not decide this question. Even assuming that the employer's interpretation of Brown is correct, nevertheless the employer's counsel did not prepare the first exhibit submission until December 7, 1987. This date is less than twenty days prior to the December 21 hearing date. Consequently, any further delay beyond December 7, 1987 occasioned by the negligence of counsel's employee is immaterial.

Accordingly, we conclude that the employer has failed to establish good cause for its untimely submission of exhibits. Further, the Referee was not required by the applicable administrative rule to consider prejudice or surprise. Moreover, the fact that the Referee did not consider these factors did not result in an abuse of discretion. We therefore review the case based only upon those documents which were admitted at hearing.

Aggravation

To establish a compensable aggravation, claimant must prove that: (1) her condition has worsened since the last award of compensation, so that she is more disabled either temporarily or permanently; and (2) her compensable injury was a material contributing cause of the worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986). Although the Referee stated that medical opinion is required to establish an aggravation claim, this is not accurate. Expert medical evidence is not required to prove a compensable aggravation. Lay testimony may be sufficient. Garbutt v. SAIF, 297 Or 148, 151-52 (1984).

Claimant testified that her condition progressively worsened while she continued working until, in September 1987, she was no longer able to maintain her employment. At that time, Dr. Campagna took her off work and requested authorization to perform surgery. This surgery was proposed for the C5-6 and C6-7

levels. Moreover, Dr. Campagna reported that claimant's problems at those levels resulted from post-traumatic aggravation of a cervical spondylosis condition which was "secondary to industrial injury of July, 1986."

Claimant's credible lay testimony, coupled with Dr. Campagna's reports, persuade us that her injury-related condition has worsened to the extent that she is more disabled than at the time of her June 19, 1987 Determination Order. Accordingly, the Referee correctly set aside the employer's aggravation denial.

Medical Services and Attorney Fees

The Board adopts the Referee's discussion of these issues.

ORDER

The Referee's order dated February 5, 1988, as republished by the Order on Reconsideration dated March 31, 1988, is affirmed. Claimant's attorney is awarded $1,359 for services on Board review, to be paid by the self-insured employer. A client-paid fee of up to $2,550 is approved.

EDWARD A. RANKIN, Claimant	WCB 88-01507
Malagon, et al., Claimant's Attorneys	November 1, 1989
Foss, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of that portion of Referee Howell's order that set aside its partial denial of claimant's chiropractic treatments for his low back condition. In his brief, claimant contends that the Referee erred in declining to assess penalties and fees for an alleged unreasonable denial. On review the issues are medical services, penalties, and attorney fees.

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

The insurer received Dr. Berry's August 25, 1987 report on September 3, 1987. Therefore, at the time of its denial, the insurer had a legitimate doubt concerning the compensability of claimant's medical services claim. Consequently, we agree with the Referee that the insurer's denial was not unreasonable.

The Referee noted that the insurer raised for the first time in its closing arguments, the contention that the current treatment was not reasonable and necessary. The denial had raised only the causal raltion issue. The Referee, nonetheless, addressed the reasonable and necessary question in his order. However, subsequent to the Referee's order, a similar situation was addressed. Patricia N. Hall, 40 Van Natta 1873 (1988). In Hall, we held that an insurer was barred from raising at hearing the question of the reasonableness and necessity of medical treatment for the first time at the beginning of a hearing. A fortiori, the issue cannot be raised for the first time in closing arguments. For this reason, we do not address the question of the reasonableness and necessity of current medical treatment.

ORDER

The Referee's order dated May 24, 1988 is affirmed. Claimant's attorney is awarded $600 for services on Board review, concerning the medical services issue to be paid by the insurer. A client-paid fee, not to exceed $800, is approved.

HOWARD L. WILLMSCHEN, Claimant
Francesconi & Associates, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney

WCB 86-17397
November 1, 1989
Order on Review

Reviewed by Board Members en banc.

The SAIF Corporation requests review of that portion of Referee Foster's order which granted claimant permanent total disability in lieu of prior Determination Orders which had awarded claimant a total of 45 percent (144 degrees) unscheduled permanent partial disability for a low back injury. On review, the issue is permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

Claimant, a corrections officer, sustained a compensable injury to his low back in March 1983, when he was knocked down while trying to stop a fight. He landed on his back and head. Claimant sustained significant physical injury from this incident. This incident resulted in a diagnosis of chronic neck and back pain.

Prior to the compensable injury, claimant had experienced low back and leg pain. In 1981, claimant underwent surgery on his back, but continued to have pain radiating into his right leg.

Claimant's regular job at the time of the compensable injury was correctional lieutenant, which was considered a management position. The job involved hazardous conditions and, occasionally, strenuous physical exertion. Following the injury, claimant accepted a demotion to communications center sergeant which was less hazardous, but involved continuous standing. This was the position claimant held at the time of his initial hearing, which concerned his appeal from an April 1984 Determination Order that awarded 15 percent unscheduled permanent disability. The prior Referee increased claimant's award of permanent disability to a total of 45 percent unscheduled permanent disability.

In August 1986, claimant's treating physician, Dr. Heder, advised SAIF that claimant was suffering from an acute change in his back condition. Dr. Heder further authorized time loss from July 14, 1986. SAIF then reopened claimant's claim.

In October 1986, Dr. Hubbard, consulting physician, diagnosed claimant as having chronic recurrent pain. Dr. Hubbard found claimant to be medically stationary with moderate disability in the back and mild to moderate disability from a chronic radiculopathy standpoint. Also in October 1986, Dr. Heder recommended that claimant continue physical therapy with access to a TNS unit and occasional office visits for treatment of the chronic pain syndrome.

A Determination Order was then issued in December 1986 awarding temporary total disability from July 14, 1986 through October 31, 1986 and no additional unscheduled permanent disability.

In February 1987, Dr. Heder completed a physical capacities report indicating that claimant could sit for up to 1 hour, stand up to 30 minutes, and walk up to 1 hour at a time for a total of 2 hours sitting, 2 hours standing, and 3 hours walking per day. Claimant could occasionally lift and carry 5 to 10 pounds, but was restricted from bending and crawling.

In July 1986 claimant was forced to quit his job as a communications center sergeant due to constant low back pain which radiated into his legs. He has not undergone surgery for this condition, but has been through a pain clinic program. Claimant is 43 years old, has graduated from high school, and has had two years of college experience which was focused on the corrections field. Claimant had worked as a corrections officer for approximately 13 years prior to his injury. He is unable to return to his last job as a communications center sergeant.

Claimant made substantial efforts to locate gainful employment but has been unsuccessful. He provided a list of approximately 50 employers he had personally contacted.

FINDINGS OF ULTIMATE FACT

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

Claimant has made reasonable efforts to obtain employment.

CONCLUSIONS OF LAW

The Referee concluded that claimant was permanently and totally disabled as a result of his compensable injury. We agree.

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful, suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant may prove permanent total disability by a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). In addition, claimant has the burden to establish that he is willing to seek regular, gainful employment and has made reasonable efforts to obtain such employment. ORS 656.206(3).

Claimant has established that he is permanently and totally disabled.

Claimant is 43 years old and the majority of his work experience is in the field of corrections. He can no longer work in the corrections field. Dr. Hubbard reported that claimant had moderate disability from a back standpoint, and mild to moderate disability from a chronic radiculopathy standpoint. Dr. Hubbard opined that claimant was permanently and totally disabled and believed claimant unable to return to work. Dr. Heder, claimant's treating physician, has given claimant permanent restrictions of sitting for 2 hours, standing for 2 hours, and walking up to 3 hours, in an 8 hour day. Further, he limited claimant's ability to lift and carry 5 to 10 pounds only occasionally. Claimant may never bend or crawl.

The vocational counselor listed five jobs he felt claimant could perform, which were approved by Dr. Heder. Although he did approve the job descriptions, Dr. Heder testified that it was his understanding that the job hours were negotiable and could be set up for a variable amount of hours and that claimant would be allowed to go home when the pain got too bad. He further indicated that performance of such jobs would be contingent on the employer's willingness to allow claimant to move around while at work as well as an understanding that claimant would occasionally and unpredictably miss up to a full day of work due to his injury.

Although the vocational counselor testified that these job descriptions fit claimant's physical capacities, he did not offer any testimony in regard to the availability of such jobs in the current labor market. Finally, there is nothing in the record to indicate that such jobs, if available, were subject to negotiation in regard to the number of hours and other limitations necessary for claimant to obtain and hold them. Accordingly, we find that at the time of the hearing, claimant was no longer able to obtain and hold gainful employment in the broad field of occupations. Gettman v. SAIF, 289 Or 609 (1980).

Claimant has sought work at numerous employers, but was unable to obtain employment due in large part to his physical restrictions. We find this to be a reasonable effort to obtain employment. ORS 656.206(3)

ORDER

The Referee's order dated May 27, 1987 is affirmed. Claimant's attorney is award a reasonable attorney fee of $600, for services on review, payable by the SAIF Corporation.

Board Member Brittingham, dissenting.

The issue is whether claimant is entitled to an an award for permanent total disability. I would reverse the order of the Referee. Therefore, I dissent.

The medical evidence does not support a finding that claimant is permanently and totally incapacitated. Moreover, when his physical limitations are combined with his social/vocational factors, I am likewise not persuaded that claimant is entitled to an award of permanent total disability. Finally, although claimant appears to be motivated to seek employment, I am not convinced that the five job descriptions, previously approved by his attending physician, are not gainful and suitable employment opportunities, the duties of which would be within his physical capabilities.

I base my conclusions on the following reasoning.

Dr. Heder, claimant's treating physician never asserted that claimant could not work or that he was permanently and totally incapacitated. Instead, Heder indicated that claimant could perform sedentary work by approving five job descriptions which he felt claimant could physically accomodate.

The majority correctly finds that the vocational counselor testified that the job descriptions, which the treating

physician approved, fit within claimant's physical capacity reports. Yet, they discount this evidence by concluding that the record is silent as to whether such jobs, if available, could be modified to accomodate claimant's limitations. I submit that the majority is inappropriately shifting the burden of proof concerning this issue from claimant to the employer.

The law is well settled that it is claimant's burden to establish that he is unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). I suggest that claimant has failed to meet his burden of proof. Specifically, he has failed to rebut the vocational evidence, which persuasively established that suitable jobs within his physical limitations are available within the current labor market. Moreover, there is nothing in the record to indicate that such jobs could not be modified in the event of a periodic flareup of symptoms.

In my view, it is not unrealistic to say that this 43 year old claimant, who possesses transferable skills and some college education, has a reasonable expectation of being able to sell his services to an employer. Consequently, I submit that claimant has not sustained his burden of proving that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

I would reverse the Referee's permanent total disability award and proceed to an evaluation of claimant's permanent disability award to determine whether claimant has been sufficiently compensated.

DENISE M. BOWMAN, Claimant
Welch, Bruun & Green, Claimant's Attorneys
William Dickas, Attorney

WCB 87-18040
November 2, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The noncomplying employer requests review of Referee Fink's order that assessed it penalties and attorney fees.

ISSUE

Whether the noncomplying employer should be assessed a penalty and/or attorney fee for its delay in paying an amount agreed upon in a Disputed Claim Settlement.

FINDINGS OF FACT

On October 6, 1987, the noncomplying employer's attorney wrote a letter to the Hearings' Division stating, inter alia, that he was "holding" his client's check and upon approval of the Disputed Claim Settlement, would deliver the check to claimant. The settlement issued on October 16, 1987. Shortly thereafter, a question arose about the repayment of a separate loan obligation between claimant and the noncomplying employer. Inasmuch as the loan had been overdue since April, 1986, the noncomplying employer apparently considered offsetting the amount of loan from its settlement payment. Ultimately, the noncomplying employer decided not to offset the amount of the loan. On November 23, 1987, it mailed claimant her settlement check.

CONCLUSIONS OF LAW

The issue at hand, i.e, the assessment of penalties and attorney fees for an employer's delay in paying an amount agreed upon in a Disputed Claim Settlement, was recently addressed by the Oregon Court of Appeals in Howard v. Liberty Northwest Ins., 94 Or App 283 (1988). In Howard, the court determined that the payment to which the worker was entitled under the settlement was not "compensation" as defined in former ORS 656.005(9). It, therefore, concluded that there was no statutory provision authorizing the assessment of a penalty. 94 Or App at 287.

Here, like Howard, the employer delayed paying the amount agreed upon in the settlement. The legal issue presented in Howard is the precise issue presented here. Applying the Howard court's reasoning to the instant case, we conclude that the amount agreed upon in the settlement was not "compensation." Accordingly, claimant is not entitled to a penalty.

Neither is claimant entitled to an attorney fee. Because there is no compensation, there cannot be unreasonable resistance to the payment of compensation which would trigger a fee under ORS 656.262(10) and 656.382. Ellis v. McCall Insulation 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989).

ORDER

The Referee's order, dated March 1, 1988, is reversed.

CONRAD N. DELANOY, Claimant
David C. Force, Claimant's Attorney
Thomas E. Ewing, Assistant Attorney General

WCB 86-11549
November 2, 1989
Order on Remand

Reviewed by Board Members Nichols and Crider.

This matter is before the Board on remand from the Court of Appeals. Delanoy v. Western Shake Company, 96 Or App 699 (1989). The court has reversed our prior order which affirmed without opinion Referee Thye's order which declined to grant claimant permanent total disability. The court found the Referee's order inadequate for review, specifically with regard to claimant's motivation to return to work. We have been instructed to reconsider this case in light of the court's opinion. After conducting our reconsideration, we issue the following order.

Claimant requests review of those portions of Referee Thye's order which: (1) declined to grant permanent total disability; (2) increased his scheduled permanent disability award for the loss of use or function of his left leg from 45 percent (67.5 degrees), as awarded by two Determination Orders and an amended stipulation, to 75 percent (112.5 degrees); and (3) increased his unscheduled permanent disability award for a low back condition from 35 percent (112 degrees), as awarded by a Determination Order, to 100 percent (320 degrees). On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

Claimant is a 42 year old man with education through

the tenth grade and no GED. He is barely able to read and write, but has good math skills. His first employment was shoveling oysters in Washington, where he injured his right knee in 1963. This worsened until Dr. Manley, an Oregon orthopedist, fused the knee in 1977. Claimant was awarded 37.5 percent permanent disability for his right knee on a Washington claim. He has also received a 10 percent Washington award for an old injury to his right hand, where he has no feeling in this little finger, causing him to drop things occasionally. Claimant has also had low back problems since a January 1975 altercation with a policeman. A late 1978 flare-up, involving the right hip and leg, was attributed to claimant's shortened right leg due to the knee fusion.

Claimant has previously worked in the woods, driven gravel truck, and operated heavy equipment. In approximately 1966 he became part owner of a shake mill, in which he worked until approximately 1976. In early 1978 he began working in the employer's shake mill as a sawyer. In July 1979, he twisted his left knee when he stepped on a shake. Dr. Manley diagnosed medial collateral ligament strain and performed an arthroscopic examination. A subsequent arthoscopic examination resulted in further diagnoses of chondromalacia and synovitis. The claim was closed by a September 1980 Determination Order which awarded claimant 20 percent scheduled permanent disability for loss of use or function of the left leg.

In March 1981 claimant returned to work in another shake mill. A November 1981 Stipulation increased claimant's scheduled left knee award to 35 percent. The claim was reopened in December 1981 for a patellar shave by arthroscope. The claim was reclosed by an August 1982 Determination Order with no further award of permanent disability.

Vocational services began in mid-1982 at which time an authorized training program was recommended. In November 1982 claimant's left knee stability worsened. This resulted in the performance of a major ligamentous reconstruction in January 1983. Claimant's recovery was set back in October 1983 when he stepped in a hole. A diagnostic arthroscopy in December 1983 revealed a rupture of the anterior cruciate ligament reconstruction, which led to further major ligament reconstruction, including the ileotibial band, in January 1984. Thereafter, claimant returned to Dr. Manley for conservative care.

Vocational services with Accra Rehabilitation began in December 1984. Dr. Manley approved a work evaluation program; however, claimant left after the first day. As a result he was referred to Dr. Parvaresh, a psychiatrist, in May 1985. Claimant was found to have a passive-dependent personality and pain medication abuse affected his mentation.

In January 1986 claimant was evaluated at a vocational evaluation center. Sedentary jobs were identified that claimant might be able to perform after on-the-job training and basic education courses to improve his reading. Throughout the period that Accra provided vocational services, claimant was living in Washington state where he was born and raised. During that time, claimant was told that he could not get vocational services while living in Washington.

In March 1986, Accra reported to the SAIF Corporation

that claimant be contacted to determine whether he wished to return to work. On May 9, 1986, SAIF wrote claimant terminating services. The termination letter alleged that claimant had not responded to a communication of April 9, 1986, and, thus, that SAIF assumed services were being declined.

In fact, claimant returned to Oregon in April 1986 in order to obtain vocational services. At the time of hearing, claimant lived in Tillamook, Oregon.

No specific on-the-job training or basic education program has ever been offered to claimant.

The claim was closed by an August 1986 Determination Order which increased claimant's scheduled permanent disability to 45 percent and 35 percent unscheduled permanent disability.

Claimant is limited to sitting no longer than 30 minutes and standing no longer than 20 minutes. His left knee gives out, especially on stairways, causing him to fall frequently. He can occasionally lift and carry up to 10 pounds, but cannot kneel, crawl or crouch. He has difficulty walking for any length of time and suffers from pain in his left knee, back, right hip and ankle. He is severely disabled. He is unable to perform gainful and suitable work without basic education and training.

FINDINGS OF ULTIMATE FACT

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

Claimant's physical limitations, in conjunction with his lack of education and transferable skills, make it futile for him to participate in vocational rehabilitation. Thus, he has made reasonable efforts to obtain employment.

CONCLUSIONS OF LAW

The Referee found claimant to be unemployable. Nevertheless, he declined to grant permanent total disability on the basis that claimant had not established that he was willing to make reasonable efforts to attempt to return to the labor market. We disagree.

At the outset, we do agree with the Referee's assessment that claimant has significant physical limitations and is currently unemployable. Dr. Manley indicated on numerous occasions that claimant's limitations were severe and that he considered him 100 percent disabled. This assessment is in line with the Orthopaedic Consultants' opinion that although claimant may be able to do sedentary work, it would be contingent upon retraining and probably have to be performed in claimant's home. Therefore, the question becomes whether claimant has made reasonable efforts to return to the work force.

ORS 656.206(3) provides:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that

the worker has made reasonable efforts to obtain such employment."

We believe that he has. Claimant, while initially reluctant to participate, did ultimately cooperate in the evaluation process in January 1986. Nevertheless, he was terminated from the program in May 1986. There is no evidence that he was sent notice that he would be terminated or that he received such notice. In any event, he returned to Oregon prior to termination in order to obtain vocational services. SAIF's assumption that he had declined vocational services is incorrect. He participated insofar as services were offered. He never declined to participate in any program. Under these circumstances we find that claimant did not refuse services.

In any event, we are persuaded that participation would have been futile.

On May 9, 1986, SAIF sent claimant a letter which informed him that vocational services were being terminated as of May 1, 1986. The letter noted that claimant had not responded to an April 9, 1986 letter, therefore it was assumed he no longer desired vocational assistance. There is no evidence that a letter was actually sent to claimant on April 9, and, if so, whether he received it. There is no evidence that claimant consented to the termination or that he wished to terminate vocational services. In fact, he returned to Oregon precisely in order to get such services.

Although Dr. Manley approved claimant's participation in the January 1986 vocational evaluation, he did not specifically approve a vocational program. In fact, he opined on numerous occasions that claimant was permanently and totally disabled and that retraining would not be worthwhile in view of claimant's limitations and background. This is supported by Dr. Fleming's opinion that claimant was permanently totally disabled. He agreed with the vocational assessment regarding claimant's abilities and aptitudes, but opined that claimant did not have the stamina or endurance to perform work on a regular basis. He further opined that the specific jobs that were recommended by Accra did not take into account the level of pain claimant would experience in performing them and how it would impact on his ability to maintain such occupations.

In conclusion, we hold that claimant was not able to participate in vocational rehabilitation in January 1986. Any efforts to do so would be futile. See Butcher v. SAIF, 45 Or App 318 (1983). In reaching this conclusion we are aware that Accra believed there were jobs within claimant's physical limitations, however she reported that they would require on-the-job training and a basic education course, neither of which were ever offered to claimant. Further, the evidence suggests that if such training were offered, claimant would by unable to participate due to his physical disabilities.

Accordingly, we conclude that claimant has satisfied ORS 656.206(3). Therefore, he is entitled to permanent total disability.

ORDER

The Referee's order dated March 30, 1987, is reversed.

Claimant is granted permanent total disability as of February 12, 1987. The SAIF Corporation is authorized to offset the permanent partial disability paid pursuant to the Referee's order against the permanent total disability award. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,000.

TIMOTHY O. FETTERHOFF, Claimant
Kenneth D. Peterson, Jr., Claimant's Attorney
Meyers & Terrall, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-10207 & 86-10206
November 2, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of Referee Podnar's order that set aside its denial of claimant's "new injury" claim for his current low back condition. The issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in April 1982, while working for a self-insured food processor. A herniated disc at L5-S1 was diagnosed and a discectomy was performed in August 1982. After the surgery, claimant continued to experience pain in his back in addition to pain, numbness and tingling in his right leg. His impairment was rated as mild and the claim was closed by Determination Order in July 1983, with a 25 percent unscheduled award. The claim was reopened during 1984, and was closed again by Determination Order in February 1985, with no additional award of permanent disability.

Claimant subsequently obtained employment as a group home worker for SAIF's insured. In April 1986, while working at the group home, claimant attempted to separate two residents who were fighting. Claimant was knocked down during the incident and landed on his back against the edge of a step. Although he completed his shift that day, claimant did not return to work.

After the accident, claimant experienced increased low back pain and he sought treatment from Dr. Weeks, his treating physician. Claimant filed a new injury claim against SAIF. It issued a denial on June 24, 1986, and requested designation of a paying agent under ORS 656.307. The self-insured employer agreed that compensability was not contested. A .307 order issued on July 31, 1986.

ULTIMATE FINDINGS OF FACT

Claimant suffers from two separable conditions, a post-surgery low back condition and a low back strain. Claimant's current post-surgery condition is related to his 1982 compensable injury with the self-insured employer.

The 1986 incident, which occurred while claimant was working for SAIF's insured, did not independently contribute to a worsening of claimant's underlying post-surgery low back condition. However, the 1986 incident caused claimant's low back strain.

CONCLUSIONS OF LAW

Based on claimant's testimony and the medical evidence, the Referee found that claimant suffered from two separable conditions. The Referee held that the self-insured employer was responsible for claimant's 1982 post-laminectomy situation, while the 1986 employer and its insurer SAIF, were responsible for claimant's musculoligamentous strain. We agree.

In successive injury cases, the first employer remains responsible if the second injury takes the form of a recurrence of the first and the second incident did not contribute to the causation of the disabling condition. If, on the other hand, the second incident independently contributed, however slightly, to the causation of the disabling condition, the second employer is solely responsible. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244, 675 P2d 1044 (1984); Hensel Phelps Const. v. Mirich, 81 Or App 290, 294, 724 P2d 919 (1986).

When the issue is whether claimant suffered an aggravation (the responsibility of the first employer) or a new injury (the responsibility of the second employer), worsened symptoms alone will not be enough to place responsibility upon the second employer. Hensel Phelps Const. v. Mirich, supra. To shift responsibility, there must be a worsening of the underlying condition. 81 Or App at 294.

In Cascade Corporation v. Rose, 92 Or App 663 (1988), the court determined that two successive injuries could be distinct enough that they could be segregated in terms of causation and responsibility. In other words, when claimant's second injury did not independently contribute to a worsening of the underlying condition, the last injurious exposure rule did not apply.

Here, we find that claimant suffers from two separate and distinct conditions, i.e., a post-laminectomy low back condition and a low back strain. Therefore, we agree with the Referee's segregation of responsibility. Claimant's treating physician described claimant as having a "new injury superimposed on the old." The Orthopaedic Consultants concluded that the examination showed claimant to have sustained a "new sprain" on April 13, 1986, and Dr. Langston reported that claimant sustained a "musculoligamentous strain" as a result of his April 1986, fall.

Although SAIF contends that the 1986 incident merely represents a symptomatic worsening of claimant's 1982 injury, three doctors, including claimant's treating physician, have found the 1986 strain to be a distinct injury. Additionally, claimant's testimony that he suffered from a different type of pain (pain in the left side of the low back) than he experienced before the 1986 incident, demonstrates the existence of a new injury, rather than a mere flare-up of symptoms from the previous injury. Under such circumstances, we find SAIF responsible for claimant's April 13, 1986, back strain.

Finally, the evidence demonstrates that the 1986 injury with SAIF's insured did not independently contribute to claimant's post-laminectomy condition. Dr. Langston, orthopedist, opined that the 1986 incident had temporarily increased claimant's symptoms from his laminectomy, but had not materially worsened his

condition. Moreover, Dr. Weeks, claimant's treating physician, concluded that the 1986 new injury represented, "only a re-exacerbation of (claimant's) previous underlying problem."

Claimant reported to Dr. Weeks that there was very little difference between his present status and his pre-injury status. Claimant testified that at the time of the hearing, he felt from a physical standpoint that he would be able to go back and perform the duties he had been carrying out at SAIF's insured prior to the 1986 incident.

The medical opinions, in addition to claimant's own testimony, persuade us that the 1986 incident with SAIF's insured did not independently contribute to a worsening of claimant's 1982 post-laminectomy condition. We therefore agree with the Referee that the self-insured employer remains responsible for claimant's post-laminectomy condition.

ORDER

The Referee's order, dated April 2, 1987, is affirmed. A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $176.

JERRY E. HENDERSON, Claimant
Bloom, Marandas & Sly, Claimant's Attorneys
Waggoner, et al., Defense Attorneys
Carrol Smith (SAIF), Defense Attorney

WCB 87-11896 & 87-04134
November 2, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of those portions of Referee Smith's order that: (1) set aside the SAIF Corporation's denial, as the insurer for Continental Drivers (Continental), of his aggravation claim for a low back condition; and (2) upheld SAIF's denial, on behalf of K & L Corporation (K & L), a noncomplying employer, of a "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant injured his low back on November 28, 1983, while employed by Continental, when he fell off his truck during unloading. He filed an injury claim with SAIF. The claim was accepted as a disabling injury.

In 1984, claimant underwent multiple low back surgeries at the L3 through L5 levels. Following these surgeries, claimant continued to experience constant pain in the low back radiating down the back of the legs into the calves, more on the left side. He also experienced pain radiating into the groin on the left side and numbness and tingling of the left leg.

On July 3, 1985, claimant received an award by Determination Order of 35 percent unscheduled permanent partial disability.

On May 16, 1986, claimant and SAIF stipulated to a reopening of his claim. The claim was closed again by Determination Order dated February 4, 1987, which awarded claimant an additional 10 percent unscheduled permanent disability, for a total award of 45 percent unscheduled permanent disability.

On February 5, 1987, claimant commenced work for K & L as a long-haul truck driver. Immediately prior to commencing such work, claimant was experiencing constant burning pain in the low back, continual shooting pain down the back of the left leg, daily right thigh pain, left calf pain, and a constant throbbing in the left ankle.

Claimant worked for K & L through April 30, 1987, at which time increased symptoms forced him to quit. These symptoms were of the same type as those he experienced prior to his employment with K & L.

On May 27, 1987, claimant filed an aggravation claim with SAIF as the insurer for Continental. SAIF denied the claim on both compensability and responsibility grounds.

On June 18, 1987, claimant filed a "new injury" claim against K & L.

On August 6, 1987, an order of noncompliance was issued by the Workers' Compensation Department against K & L.

Claimant requested issuance of an ORS 656.307 order on July 2, 1987 and again on July 7, 1987. The request was denied on September 11, 1987, due to SAIF's denial of compensability.

On October 2, 1987, SAIF issued a denial, on behalf of K & L, on both compensability and responsibility grounds.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that the Referee erred both legally and factually. With regard to the alleged legal error, claimant contends that the Referee should have applied the Kearns "rebuttable presumption" which holds that the carrier on the risk at the time of the most recent injury has the burden of proving that some other accepted injury last contributed independently to the condition which gives rise to the claim for compensation. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). Claimant further contends that, factually, the Referee should have found that claimant's employment with K & L did independently contribute to a worsening of his underlying condition.

We do not accept claimant's legal argument. The Kearns "rebuttable presumption" applies to cases involving multiple accepted claims. In successive injury cases such as the present case, where only the original claim has been accepted, Kearns does not apply. Rather, the correct standard is set forth in Hensel Phelps Construction v. Mirich, 80 Or App 290 (1986). See Olen D. Ragsdale, 40 Van Natta 892, 895 (1988).

In Hensel Phelps v. Mirich, supra, the court held that the last insurer is responsible for a worker's disability and medical treatment if an injury or the work activities at the time it is on the risk independently contributed, even slightly, to a worsening of the worker's underlying condition. On the other hand, the first insurer remains responsible if the second injury takes the form of a recurrence of the first and the second incident did not contribute to the causation of the disabling condition. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984).

Claimant notes in this regard Dr. Mason's June 23, 1987 report which refers to significant joint changes at the L3-4 and L4-5 levels. However, Dr. Mason's report does not attribute those changes to claimant's employment with K & L. In addition, consulting chiropractor Bussanich opined two days later that claimant's worsened condition was a result of a normal, progressive degenerative process originally caused by the 1983 injury and resulting surgical intervention. We, therefore, are not persuaded by Dr. Mason's report.

Claimant also notes several reports from his treating chiropractor, Dr. Close. Dr. Close noted significantly worsened findings following claimant's employment with K & L. However, Dr. Close's reports do not persuasively explain whether the worsened findings represent a symptomatic exacerbation of claimant's condition, or, instead, a worsening of the underlying pathology. Dr. Close's reports do include a statement to the effect that claimant's driving activities for K & L independently contributed to a worsening of his preexisting condition. However, this statement is unsupported by any explanation. Moreover, the statement is inconsistent with Dr. Close's prior reports wherein he notes only worsened symptoms. We, therefore, attach little persuasive weight to this statement. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Finally, Dr. Close opines several times that claimant's worsened symptoms "could" constitute a new injury. However, a mere possibility of worsened pathology is insufficient to shift responsibility to K & L. See Gormley v. SAIF, 52 Or App 1055 (1981).

In addition, claimant's reported symptoms do not support a finding of worsened pathology. In this regard, claimant underwent a physical capacities evaluation shortly before hearing. At that time, he reported constant, burning low back pain; constant pain down the back of his left leg to his ankle; and intermittent right thigh and leg pain. These symptoms are precisely the same symptoms claimant reported during a work tolerance screening performed just prior to the date he commenced work for K & L. This lack of evidence of new symptoms is additional support for our conclusion that claimant has failed to established an independent contribution to a worsening of his underlying condition as a result of his employment with K & L.

ORDER

The Referee's order dated January 13, 1988 is affirmed. A client-paid fee in the amount of $1,179, payable by the SAIF Corporation to its outside counsel appearing on behalf of K & L Corporation, is approved.

JOSEPH J. HRITZ, Claimant	WCB 86-17887
Patrick Lavis, Claimant's Attorney	November 2, 1989
SAIF Corp Legal, Defense Attorney	Order on Review

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Knapp's order that upheld a denial of claimant's occupational disease claim for a respiratory condition. On review, the issue is compensability.

We affirm.

FINDINGS OF FACT

Claimant began working on a maintenance crew with the SAIF Corporation's insured in July 1975. His duties included work at a sewage treatment plant where he was exposed to chlorine fumes on a daily basis. He experienced a respiratory attack in 1977, characterized by high fever, shortness of breath, exhaustion, coughing and sputum production. Claimant had experienced no previous respiratory problems, but he had smoked an average of one pack of cigarettes a day since age 18.

Claimant quit smoking after his respiratory attack in 1977. He continued to suffer from mild respiratory flare-ups every two to three months. Sometime around May 1984, he experienced a significant respiratory attack following exposure to an unusually high level of chlorine fumes at the sewage treatment plant. His condition improved with conservative treatment and time loss, and he returned to work in June 1984. He was subsequently transferred to a different maintenance crew where he did not work in the sewage treatment plant. He had no further exposure to chlorine fumes, except for four hours in 1985. However, his new job assignment exposed him to fumes from paints, solvents and cleaning fluids.

On March 22, 1985, claimant experienced shortness of breath while installing fence posts at work, and he filed an occupational disease claim. In April 1985, SAIF issued a denial for "a shortness of breath suffered [by claimant] on March 22, 1985." In support of its denial, SAIF contended that claimant's shortness of breath was "not caused nor materially worsened by [his] work activities on March 22, 1985." Claimant did not appeal the denial, and it became final as a matter of law.

Claimant continued to experience respiratory attacks, and he filed a second occupational disease claim in April 1986. The following July he sought treatment from Dr. Fuchs, a pulmonary specialist. Dr. Fuchs diagnosed moderately severe obstructive lung disease with an asthmatic component. Claimant was transferred to a new job assignment which did not expose him to respiratory irritants, but his symptoms continued. He left his job with SAIF's insured in September 1986, and he has not worked since. On December 9, 1986, SAIF issued a denial of claimant's April 1986 occupational disease claim, and claimant requested a hearing. It is SAIF's December 9, 1986 denial that is presently before the Board on review.

At the time of hearing, claimant continued to suffer from significant respiratory problems. He has experienced a gradual increase in symptoms since the onset of his condition in 1977. In addition to his lung disease, claimant has a history of heart problems and viral infections.

FINDINGS OF ULTIMATE FACT

Work exposures were not the major contributing cause of the onset or worsening of claimant's respiratory condition.

CONCLUSIONS OF LAW AND OPINION

We do not entirely agree with the Referee's analysis of this case, but we affirm his ultimate conclusion with the following comment.

Claimant has sustained a compensable occupational disease if his work activity was the major contributing cause of the onset or worsening of his current respiratory condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). The record contains evidence of a number of non-work factors that may have contributed to claimant's respiratory problems, including a history of cigarette smoking, heart disease and viral infections. The causation of claimant's current condition is, therefore, a complex medical question requiring expert medical analysis.

The only medical opinions on this issue are from Dr. Fuchs, the treating physician, and Dr. Montanaro, who performed an independent medical examination. Both doctors are specialists in pulmonary disorders. They agreed that claimant's cigarette smoking was the major contributing factor to the onset of his lung disease in 1977. Like the Referee, we defer to their opinion and conclude that claimant's work activity was not the major contributing cause of the onset of his respiratory condition.

Nevertheless, claimant's current condition is compensable if work activity was the major contributing cause of a worsening of the condition. In this regard, the Referee charged claimant with demonstrating that work exposure after April 1985 worsened his disease. The Referee premised that ruling on an overly broad reading of SAIF's April 1985 denial. That denial finally determined that claimant's shortness of breath on March 22, 1985 was "not caused nor materially worsened by [his] work activities on March 22, 1985." The Referee reasoned that the denial "estopped [claimant] from proving his pre-1985 work condition caused or aggravated his lung disease."

We, instead, conclude that SAIF's April 1985 denial did not address the effect of his work exposure either before or after March 22, 1985. It only determined that claimant's work activities on that one day did not contribute to his respiratory exacerbation. Consequently, claimant need only demonstrate that work exposures either before or after March 22, 1985, were the major contributing cause of a worsening of his condition.

In resolving this issue, we again defer to the opinions of Drs. Fuchs and Montanaro. Dr. Montanaro opined that claimant's work exposure resulted in a temporary increase in symptoms but no worsening of his underlying condition. Dr. Fuchs indicated that claimant's work exposure was a major contributor to a temporary worsening of his condition during the past two years. Dr. Fuchs clarified his opinion at a subsequent deposition, at which time he clearly stated that work exposure to irritants was not the major contributing factor of claimant's current condition. Dr. Fuchs also stated that the relative contribution from smoking would be even greater if claimant had a more extensive smoking history than the one-half to one pack a day history he initially gave Dr. Fuchs. The latter statement is particularly significant in light of claimant's acknowledgment at hearing that he smoked an average of one pack of cigarettes a day, and as many as two packs on some days.

The opinions of Dr. Fuchs and Montanaro establish that claimant's work exposures were not the major contributing cause of

a worsening of his lung disease and respiratory problem. Accordingly, we affirm the Referee's ultimate decision upholding SAIF's December 9, 1986 denial.

ORDER

The Referee's order, dated February 22, 1988, is affirmed.

DAVID D. JOHNSON, Claimant
Welch, Bruun, et al., Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney

WCB 87-17277
November 2, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

The SAIF Corporation requests review of Referee Bennett's order that set aside its denial of claimant's aggravation claim relating to his right knee. We reverse.

ISSUES

1. Whether claimant's claim is barred by res judicata.

2. Aggravation of claimant's right knee condition.

FINDINGS OF FACT

Claimant sustained a contusion to his right knee on May 25, 1984 in the course of his employment as a carpet installer when he slipped and fell forward while walking up some steps. He sought medical treatment for the injury from Dr. Torres, a specialist in occupational medicine. Dr. Torres released claimant to return to regular work on May 29, 1984 and claimant returned to work on that date. SAIF accepted claimant's right knee contusion as nondisabling by Notice of Acceptance dated July 2, 1984. Claimant did not seek any treatment or miss any work in connection with his right knee from May 29, 1984 through August 19, 1985.

On August 19, 1985, at approximately 11:00 a.m., claimant robbed a convenience store. He fled the store on foot and then got into a car and drove away. About an hour and 45 minutes later, he sought treatment at a hospital emergency room for pain and swelling in his right knee. He told the examining doctor that he had hurt his knee that morning while attempting to pick blackberries when he fell and landed on his buttocks. X-rays taken at that time were normal. The doctor diagnosed a right knee strain and recommended that claimant treat the injury at home with an ice pack.

Claimant continued to experience severe pain in his knee and went to another hospital emergency room on August 21, 1985. The examining doctor inserted a needle into the joint and withdrew a considerable amount of bloody fluid. The doctor then prescribed pain medication and sent claimant home.

Claimant was arrested in connection with the convenience store robbery on August 22, 1985. The arresting officer noticed that claimant was having difficulty with his right knee. During a subsequent interview at the police station, claimant denied that he had committed the robbery. When questioned about his knee condition, claimant told the arresting officer that he had hurt his knee on August 19, 1985 while picking berries when he stepped

in a hole and fell down. Claimant was released on bail on September 13, 1985 pending his trial on the robbery charge.

On September 19, 1985, claimant was examined by Dr. Torres. Claimant told Torres that his knee had bothered him ever since the May 1984 industrial injury and would occasionally "go out" without any precipitating event. He indicated that the knee had gone out in this manner on August 19, 1985 and that he had fallen forward onto the ground. He also indicated that he wished to reopen his workers' compensation claim. Dr. Torres referred claimant to Dr. Post, an orthopedic surgeon.

Claimant told Dr. Post that he had experienced periodic "clicking" and catching in his knee ever since the May 1984 industrial injury. He indicated that the knee "clicked" and then went out on August 19, 1985, causing him to fall. Given this history, Dr. Post opined that claimant's then-current knee problem represented an aggravation of his May 1984 industrial injury. He recommended further evaluation of the condition by arthrogram and, if necessary, arthroscopy.

An arthrogram was carried out on October 7, 1985. The examining doctor noted blood-tinged fluid in the knee, but otherwise identified no abnormality. Dr. Post expressed surprise at the presence of blood in claimant's knee in view of claimant's "deny[al] of any intervening injuries that might have caused bleeding."

SAIF received the reports generated by claimant's doctors at some point during late 1985. On January 7, 1986, SAIF issued a denial of claimant's aggravation claim relating to his right knee. Claimant did not appeal the denial.

Claimant was convicted of the convenience store robbery and went to prison in April 1986. He was paroled in January 1987 and obtained employment with a company called Berglund Industries. In March 1987, claimant feigned an injury to his right knee while at work and was taken to a hospital emergency room. During the course of the examination, claimant admitted to the doctor that he had not actually injured his knee at work. The employer was informed of this and claimant's employment was terminated and he returned to prison.

After claimant's release from prison in January 1987, Dr. Post wrote SAIF stating that claimant had continued to experience problems with his knee which periodically became acute. In a subsequent letter dated February 13, 1987, Dr. Post stated that claimant was unable to work and recommended an arthroscopic examination. He also requested that SAIF begin paying time loss. SAIF treated this request as a claim for aggravation and scheduled an independent medical examination for claimant. At some point before the date of the examination, claimant left the state. SAIF was unaware that claimant had left the state and attempted to reschedule the examination, but received no response from claimant. In view of this, SAIF issued a second aggravation denial on May 6, 1987 and mailed it to claimant's last known address. Claimant was still out of the state at that time and apparently did not receive the denial. In any event, the denial was not appealed.

After returning to Oregon and spending more time in

prison because of a parole violation, claimant submitted to an independent medical examination with a panel of the Orthopaedic Consultants in October 1987. The examination revealed some signs of internal derangement of the knee and the panel recommended arthroscopic examination. This was carried out by Dr. Post on October 30, 1987. The examination revealed the complete absence of the anterior cruciate ligament, a small tear of the medial meniscus and a plica and chondromalacia of the surface of the medial femoral condyle. Dr. Post debrided and shaved the condylar surface and recommended a rehabilitative exercise program for the other abnormalities he had identified. Claimant was totally incapacitated from working for more than 14 days after the arthroscopic procedure.

SAIF issued a third aggravation denial on November 6, 1987. Claimant filed a request for hearing on this denial on November 12, 1987. The hearing was held on February 9, 1988. At the hearing, claimant admitted that he had robbed the convenience store on August 19, 1985. Claimant has also been convicted of a number of other felonies including two forgeries.

FINDINGS OF ULTIMATE FACT

1. SAIF's January 1986 and May 1987 aggravation denials are final by operation of law. Claimant's right knee condition worsened in October 1987 as a result of the arthroscopic procedure.

2. Claimant is not a credible historian.

CONCLUSIONS OF LAW

1. Res Judicata

SAIF contends that claimant's aggravation claim is barred by res judicata. The Referee rejected this argument on the ground that claimant's condition had worsened since the last unappealed denial. We agree with the the Referee's conclusion on this issue, but substitute the following analysis for his.

Claimant underwent an arthroscopic procedure in October 1987 which resulted in disability sufficient to constitute a worsening under ORS 656.273. See ORS 656.210; Smith v. SAIF, 302 Or 396, 400-01 (1986). A worsening occasioned by a medical procedure may form the basis for an aggravation claim. Chapel of Memories v. Davis, 91 Or App 232, 234 (1988). The October 1987 worsening created a set of operative facts and thus a cause of action which was distinct from those sets which became unenforceable when the January 1986 and May 1987 denials became final by operation of law. Litigation associated with the October 1987 worsening, therefore, is not precluded by res judicata. See North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988); Carr v. Allied Plating Co., 81 Or App 306, 309-10 (1986); Restatement (Second) of Judgments §§ 17-19, 24 (1982).

2. Aggravation

To establish an aggravation under ORS 656.273, claimant has the burden of proving a worsening of his condition since the last arrangement of compensation and a causal relation between the worsened condition and his compensable May 1984 industrial

injury. See Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 459, rev den 297 Or 82 (1984). As previously noted, the arthroscopic procedure in October 1987 resulted in a worsening of claimant's right knee within the meaning of ORS 656.273. The focus of inquiry, therefore, is on the causation issue.

The causation issue in this case turns on the question of whether the May 1984 industrial injury was a material contributing cause of the need for the arthroscopic procedure in October 1987. The only medical professionals to render an opinion on this question were Dr. Post and a panel of the Orthopaedic Consultants. They both thought that the procedure was related to the May 1984 injury. These opinions were based on history received from claimant to the effect that he had experienced significant ongoing symptoms in his knee ever since the May 1984 injury and that this condition had worsened suddenly in August 1985 without any precipitating event and had continued symptomatic thereafter. We conclude that claimant is not a credible historian, that the history upon which Dr. Post and the Orthopaedic Consultants based their opinions is unreliable and, thus, that claimant has failed to prove a material causal relation between his May 1984 industrial injury and his need for the arthroscopic procedure in October 1987.

Claimant sustained a relatively minor injury in May 1984. He returned to strenuous work within a few days of the injury and sought no treatment and missed no work for more than a year thereafter. Claimant experienced a sudden increase in symptoms on August 19, 1985 for which he sought emergency medical treatment. He told the examining doctor that he had hurt his knee that morning while picking blackberries and had fallen onto his buttocks. Claimant had actually been out robbing a convenience store that morning, but, did not mention this activity to the doctor. The doctor recorded no complaints of ongoing difficulty with the knee prior to August 1985. Claimant gave a similar story to the police officer, who arrested him a few days later for the robbery of the convenience store. He said that he had hurt his knee when he stepped in a hole while berry picking.

About a month later, claimant told Drs. Torres and Post a different story. He told them that his knee had bothered him more or less continuously since the May 1984 injury and had gone out on August 19, 1985 without any precipitating event, causing him to fall forward. Dr. Post later expressed surprise at the presence of bloody fluid in claimant's knee in view of this history, but continued to accept claimant's story.

Claimant is not a trustworthy historian. He has been convicted of crimes of dishonesty and deceit and, in March 1987, attempted to file a fraudulent workers' compensation claim for his knee with another employer.

In view of the inconsistent histories that claimant has given, his poor reputation for honesty, the absence of any documentation of ongoing problems with his knee between May 1984 and August 1985 and the potentially injurious event or events which immediately preceded the acute worsening of his knee on August 19, 1985, we conclude he has failed to prove by a preponderance of the evidence that the history he provided to Drs. Torres and Post and the Orthopaedic Consultants was accurate. The opinions rendered by Dr. Post and the Orthopaedic

Consultants regarding a causal relation between the May 1984 injury, the August 1985 worsening and the subsequent need for the arthroscopic procedure in October 1987, therefore, cannot be trusted. See Somers v. SAIF, 77 Or App 259, 263 (1986). Consequently, we conclude that claimant has failed to establish a compensable aggravation.

ORDER

The Referee's order dated March 7, 1988 is reversed. The SAIF Corporation's aggravation denial dated November 6, 1987 is reinstated and upheld.

GERALD W. LEWIS, Claimant
David Hollander & Assoc., Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney

WCB 88-00758
November 2, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

The SAIF Corporation requests review of that portion of Referee Bennett's order that declined to authorize an offset for allegedly overpaid temporary disability compensation. On review, the issue is offset. We reverse.

FINDINGS OF FACT

In January, 1987, claimant proceeded to hearing before Referee St. Martin, raising the issue of premature claim closure from a January, 1986, Determination Order. SAIF apparently cross-requested a hearing to obtain authorization for an offset. The prior Referee set aside the Determination Order as premature and declined to address the offset issue on the ground that it had not been timely raised.

SAIF has paid temporary disability compensation in the amount of $18,892.79 for the following time periods:

October 13, 1984, through November 5, 1984
March 9, 1985, through May 14, 1986
October 17, 1986, through April 23, 1987
November 15, 1987, through December 14, 1987.

No Determination Order or litigation order has directed SAIF to pay temporary disability compensation for these time periods.

FINDINGS OF ULTIMATE FACT

Referee St. Martin's 1986 order did not finally adjudicate SAIF's claim for offset authorization on the merits.

SAIF has overpaid temporary disability compensation in the amount of $18,892.79.

CONCLUSIONS OF LAW

SAIF seeks authorization to offset overpaid temporary disability compensation against future awards. The Referee concluded that the doctrine of res judicata precluded SAIF from raising that issue in this proceeding. We disagree.

SAIF cross-requested a hearing in this matter raising the offset issue. Claimant defended on that issue by raising the

affirmative defense of res judicata, i.e., "claim preclusion." See North Clackamus School District v. White, 305 Or 48 (1988). It was, therefore, claimant's burden to prove the elements of that defense. Troutman v. Erlandson, 287 Or 187 (1979). To prevail on a claim preclusion defense, claimant must establish either: (1) that the claim was raised and finally adjudicated in a prior proceeding involving the same parties; or (2) if the claim was not actually raised in the prior proceeding, that it could have been alleged under the same set of operative facts. Taylor v. Baker, 279 Or 139 (1977); Million v. SAIF, 45 Or App 1097 (1980).

Claimant has failed to established the essential elements of the res judicata defense. The only evidence of what transpired in the prior proceeding which appears in this record is the prior Referee's order, which states, inter alia:

> "SAIF's contention for an offset is disallowed as not being timely raised."
>
> "* * * * *.
>
> "IT IS FURTHER ORDERED that SAIF's contention for an offset is hereby denied."

As can be seen, the prior Referee's order indicates neither the type of compensation (i.e., temporary or permanent disability) nor the periods of allegedly overpaid compensation for which SAIF was seeking an offset. Accordingly, as far as we are aware, there is no evidence that the instant claim for offset, which pertains to temporary disability compensation paid for specific periods involves the same set of "operative facts" as the prior claim for "offset." Moreover, with respect to, at least, the overpayments that occurred after the date of the prior proceeding, January 6, 1987, SAIF obviously could not have raised an offset issue in the prior proceeding. Claimant has therefore failed to establish that the offset issue which SAIF now raises was previously litigated. Therefore, claimant cannot prevail on the theory that the claim was actually litigated. Like the defendant in Troutman v. Erlandson, supra, he has failed to present sufficient evidence concerning what transpired in the prior proceeding to foreclose the possibility that the issue before us was never actually litigated.

We therefore turn to claimant's contention that the offset issue is barred because it could have been raised in the prior proceeding. Claimant contends that the 1984 and 1985-1986 overpayments were ripe for litigation at the time of the 1986 hearing. While that may be true, ripeness alone is insufficient to create a res judicata bar. Claimant must also establish that the offset claim arose out of the same set of operative facts as other issues litigated in that hearing. The only issue disposed of on the merits by Referee St. Martin was a premature closure claim. The key to the premature closure issue was whether or not claimant was medically stationary on January 2, 1986. The evidence relevant to that question is very different than what is relevant to the claimed overpayments. We conclude that the offset issue presently before us did not arise out of the same set of operative facts as the premature closure issue. Claimant has therefore failed to establish a res judicata bar based on failure to raise the offset issue in the prior proceeding.

We, therefore, may decide the offset issue in this proceeding.

The Merits of the Offset Issue

SAIF has paid periods of temporary disability compensation from October 13, 1984, through December 14, 1987. (Exs. 3 & 9). Claimant does not challenge the contention that he is not entitled to compensation for those periods. For that reason and inasmuch as SAIF was never directed to pay such compensation, we have further found that there was an overpayment. The overpayment amounts to $18,892.79. Id. We, therefore, grant SAIF's request to offset its overpayment of $18,892.79 from any unpaid or future awards of permanent disability compensation. Rodney A. Vanderlin, 39 Van Natta 680 (1987).

ORDER

The Referee's order, dated May 6, 1988, is reversed in part and affirmed in part. That portion of the order that declined to grant SAIF's request for an offset is reversed. SAIF is authorized to offset its $18,892.79 overpayment from any unpaid or future awards of permanent disability compensation. All remaining portions of the Referee's order are affirmed.

JERRY P. SHULTS, Claimant
Pozzi, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Foss, et al., Defense Attorneys

WCB 86-18111, 86-01825, 86-01826, 86-01827 & 87-06440
November 2, 1989
Order on Review

Reviewed by Board Members Nichols and Crider.

Claimant requests review of the portion of Referee Blevins' order that upheld The Salvation Army's denials of his aggravation claims for a right hip condition. We reverse.

ISSUE

Aggravation

(1) Has claimant's right hip condition worsened since the last award of compensation?

(2) Did the compensable right hip injury in 1980 materially contribute to that worsening?

FINDINGS OF FACT

Claimant sustained three industrial injuries in 1980 while working as a truck driver for The Salvation Army. In July, 1980, he compensably injured his right hip when he slipped while lifting a refrigerator. He was diagnosed with right trochanteric bursitis, right piriformis strain and osteoarthritis of the right hip joint. He treated conservatively with Dr. Rabin, a chiropractor, and was taken off work for several weeks in 1981 due to the injury. The claim was closed by Determination Order on September 14, 1981, with awards of temporary disability and 25 percent scheduled permanent disability for the loss of use or function of the right leg (hip).

In September, 1980, claimant compensably injured his low back while unloading carpet from his truck. The diagnosis was a

lumbar strain. He was taken off work for a few days and treated conservatively with Rabin. That claim was closed by Determination Order on December 30, 1980, with an award of temporary disability only.

In October, 1980, claimant compensably injured his low back while loading a bathtub onto his truck. The diagnosis was moderate to severe lumbosacral strain. He was taken off work for several weeks and treated conservatively. That claim was closed by Determination Order on February 19, 1981, with an award of temporary disability only.

At the time of those injuries, claimant was also employed as a part-time bus driver for the local school district, working early mornings and late afternoons throughout the academic year. In 1983 he left employment with The Salvation Army for reasons unrelated to his injuries. He began working more hours for the school district.

Claimant did not seek treatment for his right hip from late 1981 through September, 1985, because he had been told that further treatment would not be curative. However, his right hip pain persisted and gradually increased during that time.

In October, 1985, claimant saw Dr. Adams, an orthopedist, for increasing right hip pain. He also had numbness and a burning sensation along the right leg. The diagnosis was osteoarthritis of the right hip. A comparison of claimant's then-current hip condition with x-rays taken in 1980 revealed significant progression of the osteoarthritis. Claimant did not miss any time from work due to increasing hip symptoms.

On December 9, 1985, The Salvation Army issued separate letters denying claimant's aggravation claims relating to each of the three industrial injuries in 1980, contending that claimant's condition had not worsened. The letters also denied medical services for the current hip condition as unrelated to the industrial injuries.

In June, 1986, claimant's employment with the school district was terminated for reasons unrelated to his physical condition. Claimant filed an occupational disease claim with the school district's carrier, alleging that his bus driving activities contributed to his current hip condition. That claim was denied. The Referee upheld that denial, and it is not an issue on Board review.

At hearing, claimant had constant right hip pain radiating to his right calf and, occasionally, his ankle. The pain increases sharply with sudden movements of his right leg or foot and with certain activities such as climbing or descending stairs, getting in or out of chairs, stepping off curbs, and walking on uneven ground. Tr 34, 43. He cannot walk continuously for more than 10 to 15 minutes due to the increase in hip pain and onset of numbness and burning in the right leg. Tr 43. He has problems with his right knee giving way during prolonged walking or standing. Tr 45. He also has greater difficulties sleeping in any one position for very long. Tr 40-41. At the time of hearing, claimant was working as an independent contractor, transporting two students to special education classes.

Claimant's last award of compensation was the

Determination Order of September 14, 1981. At the time of that order, claimant had chronic right hip pain with associated decreases in range of hip motion. He also had difficulty bending over from a sitting position. He could not walk continuously for more than 20 minutes on a hard floor without significant hip pain. He could not perform repetitive lifting of more then 50 pounds. Ex. 30.

FINDINGS OF ULTIMATE FACT

1. Claimant's right hip condition has worsened since his last award of compensation.

2. The compensable right hip injury in 1980 materially contributed to that worsening.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld The Salvation Army's aggravation denials, concluding that claimant failed to sustain his burden of proving that the compensable injuries in 1980 materially contributed to his current hip condition. We disagree with that conclusion.

To establish a compensable aggravation claim, claimant must prove that: (1) his right hip condition has worsened since the last award of compensation so that he is more disabled, either temporarily or permanently; and (2) his compensable injuries in 1980 materially contributed to that worsening. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986). For the sake of clarity, we begin with the causation element of the test.

Causation

All of the medical evidence on causation was generated by Dr. Adams, claimant's treating orthopedist. Adams opines that claimant's arthritic right hip preexisted the 1980 injuries and that the injuries did not contribute to the progression of the arthritic process itself. He adds, however, that the injuries had a "material role" in the symptomatology of hip pain. Ex 41, 44-30. Adams also opines that claimant's excessive weight is the "major" or "main" problem.

To be a "material contributing cause," the injuries need not be the sole, or even principal, cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987). Taking all of Dr. Adams's reports and testimony as a whole, we are persuaded that the compensable injuries in 1980 were a material contributing cause of claimant's increased right hip symptoms. We next determine whether those increased symptoms constitute a worsening of claimant's condition.

Worsened Condition

Increased symptoms involving a scheduled body part, in and of themselves, do not establish a worsened condition unless they result in a greater loss of function of the body part than was anticipated by the last award of compensation. See Gwynn v. SAIF, 304 Or 345, 352 (1987); Smith v. SAIF, supra, 302 Or at 401. Claimant persuasively testified that his symptoms and physical

limitations have steadily increased since the last award of compensation in 1981. In addition to hip pain that has persisted since 1981, he now has numbness and burning in the right leg during certain activities such as prolonged walking. Whereas he could walk continuously for 20 minutes in 1981, he can now do so for only 10 to 15 minutes. He also testified to greater problems with sleeping and agility. He now cannot walk on uneven ground and has greater difficulty with numerous activities requiring placement or support of the right leg and foot. After reviewing this record, we are satisfied that increased symptoms have resulted in a greater loss of function of the right hip than was anticipated by the last award of compensation. We find, therefore, that claimant's increased hip symptoms constitute a "worsened condition" under ORS 656.273(1). Claimant's aggravation claim is compensable.

ORDER

The Referee's order dated February 1, 1988 is reversed in part and affirmed in part. The portion of the Referee's order that upheld The Salvation Army's December 9, 1985, denial of claimant's aggravation claim relating to the industrial injury of July 7, 1980, is reversed. That denial is set aside and claimant's aggravation claim is remanded to The Salvation Army for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded assessed fees of $2,000 for services rendered at hearing and $500 for services rendered on review. The Board approves a client-paid fee not to exceed $2,396, payable to The Salvation Army's counsel. A client-paid fee not to exceed $360 is also approved for Liberty Northwest Insurance Corporation's counsel.

NANCY V. STOREY, Claimant
Charles D. Maier, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 87-01651
November 2, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

The insurer requests review of that portion of Referee Michael Johnson's order that: (1) set aside its "de facto" denial of claimant's October 17, 1986 injury claim; and (2) assessed penalties and attorney fees for unreasonable claims processing. On review, the issues are compensability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was 43 years of age at hearing. She suffered a compensable injury in February 1984 to her low back. The claim was accepted as nondisabling.

On Friday, October 17, 1986, while working for the same employer, claimant slipped at work and fell against a wall. She suffered pain in her shoulder and low back. She was off work over the weekend and went to work on Monday, October 20, 1986. She was then off work for three days and completed a Form 801 describing her accident. On it, claimant states that her left foot slid forward and she hit her shoulder on the wall when she tried to catch herself. Claimant identified the injured body part as the shoulder. This form was completed and signed by the employer on October 23, 1986.

The insurer accepted the claim as a nondisabling injury on October 31, 1986 by marking the boxes on the Form 801. Claimant did not receive a copy of the 801.

Dr. Snider signed a supplemental medical report (Form 828) on November 14, 1986, which stated that claimant was last treated on May 27, 1986 and which also gave the 1984 injury as the date of injury.

On January 2, 1987, the insurer filed a Form 1502 with the Evaluation Division which referred to the February, 1984, injury. The insurer indicated that it was deferring acceptance or denial on a disabling aggravation claim.

Claimant continued to work until January 7, 1987. She was taken off work on that date by Dr. Anderson, chiropractor. On January 26, 1987, Dr. Anderson reported that claimant was suffering from left leg and hip pain due to the October 17, 1986 injury. The report was received by the insurer on February 2, 1987.

On January 29, 1987, claimant filed a request for hearing indicating the issues would include "de facto" denial and failure to classify the injury as a new injury claim.

On February 11, 1987, Dr. Anderson filed a Form 828 with the Division indicating that he was treating claimant for a new injury suffered October 17, 1986 and that claimant would be off work until a consultation with a neurosurgeon. It was received by the insurer on February 18, 1987.

On April 7, 1987, the insurer filed a new Form 1502 accepting the claim as a nondisabling new injury. The temporary total disability rate under the 1984 claim was less than the rate under the 1986 "new injury" claim. Thereafter, the insurer adjusted the temporary disability rate to reflect payment under the 1986 claim.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that "acceptance" on a Form 801 does not constitute a formal acceptance because it does not meet the four specific requirements of ORS 656.262(6). The Referee also held that the payment of benefits keyed to claimant's 1984 injury did not constitute an acceptance of the 1986 injury. Therefore, the Referee found a "de facto" denial of the 1986 injury claim

The insurer takes the position that its completion of the 801 claim form constituted a valid acceptance. We agree. Acceptance of a claim is accomplished by checking the appropriate options on a claim form. U. S. Bakery v. DuVal, 86 Or App 120 (1987). See also Georgia-Pacific v. Piwowar, 305 Or 494 (1988); Johnson v. Spectra Physics, 303 Or 49 (1987).

Claimant contends, nevertheless, that acceptance by check-the-box on an 801 form is not a formal acceptance if, in fact, claimant never received her copy of the 801. We disagree. An 801 form is not required to be mailed to claimant in order to be a valid acceptance. Even if it were, there is no evidence that it was not in this case. In any event, "acceptance" is an act

through which the insurer acknowledges responsibility for the injury or condition contained in a claim and obligates itself to provide the benefits due under the law in a writing of the type that is ordinarily addressed to the claimant.

Claimant confuses the act of acceptance with the insurer's responsibility to furnish notice of that acceptance under ORS 656.262(6). Notice occurs after acceptance has been accomplished. The question of whether notice has been properly furnished is one of claims processing, not a question of whether or not a claim has been accepted.

Here, claimant's October 17, 1986 injury was accepted by the insurer's completion of the Form 801 on October 31, 1986. The Referee erred in finding there was a "de facto" denial of the claim.

The Referee assessed a penalty and an attorney fee based on the aforementioned "de facto" denial analysis. Although we agree with the Referee's assessment of a penalty and attorney fee, we do so for a different reason. We conclude that the insurer was unreasonably slow in redesignating the October 1986 injury as disabling and paying temporary total disability benefits under the 1986 claim rather than claimant's 1984 claim. The insurer had notice of the time loss authorization for the new injury on February 2, 1987. The insurer unreasonably continued to treat the claim as an aggravation until April 1987. The penalty and fee, as assessed by the Referee, is affirmed.

ORDER

The Referee's order dated October 5, 1987, is reversed in part and affirmed in part. That portion of the order that set aside a "de facto" denial and awarded a $1200 attorney fee is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the insurer to its counsel, not to exceed $571.50, is approved.

JOSEPH SWEET, Claimant
Reynolds & Swift, Claimant's Attorneys
Kilpatrick & Pope, Defense Attorney
Carl Davis, Assistant Attorney General

WCB 87-03179
November 2, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Wasley's order that dismissed his hearing request as untimely filed. On review, claimant contends that: (1) his hearing request was timely filed; (2) his bilateral leg injury is compensable; and (3) a penalty and related attorney fee should be assessed for the employer's allegedly unreasonable failure to accept or deny the claim within 60 days. We reverse.

ISSUES

1. Timeliness of claimant's hearing request.

2. Compensability of claimant's bilateral leg injury.

3. Penalty and attorney fee for the employer's allegedly unreasonable failure to accept or deny the claim within 60 days.

FINDINGS OF FACT

We adopt the first through fourth paragraphs in the "FINDINGS OF FACT AND CONCLUSIONS" portion of the Referee's order, with the following supplementation. Although the employer knew of the injury on September 11, 1986, the employer neither accepted nor formally denied responsibility for the injury. Claimant filed his hearing request on February 27, 1987, more than five months later.

FINDINGS OF ULTIMATE FACT

The motor vehicle accident on September 11, 1986, was a work-related event. That accident materially contributed to claimant's bilateral leg injury and resulting need for treatment.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

The Referee correctly found that the employer had actual knowledge of claimant's injury on the date of injury, but that the employer never accepted or denied responsibility for the injury. The Referee correctly reasoned that the injury claim was denied "de facto" after November 10, 1986, the sixtieth (60th) day after the employer knew of the injury. See ORS 656.262(6); Barr v. EBI Companies, 88 Or App 132, 134 (1987); Syphers v. K-W Logging, Inc., 51 Or App 769, 771, rev den 291 Or 151 (1981). However, the Referee then cited Syphers, supra, for the proposition that claimant must file his request for hearing on the "de facto" denial within 60 days after that denial. Because claimant failed to file his hearing request within 60 days after November 10, 1986, the designated date of the "de facto" denial, and failed to establish good cause for his failure to do so, the Referee concluded that the hearing could not be granted. We disagree with the Referee's legal proposition and conclusion.

We have previously stated that there is no limitations period for filing a request for hearing on a "de facto" denial. Roger G. Prusak, 40 Van Natta 2037, 2040 (1988). ORS 656.319(1)(a) provides that a hearing on a denial of compensation shall not be granted unless the hearing request is filed within 60 days after "claimant was notified of the denial." Additionally, ORS 656.262(8) provides in relevant part that a worker may request a hearing on a denial "within 60 days after the mailing of the notice of denial." Here, there is no evidence that any notice of denial was ever mailed to claimant. Claimant never received notification of the denial. Accordingly, the 60-day limitations period never commenced.

The Referee's reliance on Syphers, supra, is misplaced. In that case, the court merely held that a hearing request is premature and ineffective if it is filed before acceptance or denial of a claim and within the 60-day limitations period for accepting or denying the claim. Id. The court in Syphers said nothing concerning a limitations period for filing a hearing request on a "de facto" denial. Hence, that case is inapposite here.

On review, the employer offers Barr v. EBI Companies, supra, as authority supporting the Referee's decision. We are not

persuaded. The court in Barr, supra, stated that "[a] claimant may request a hearing on a denial within 60 days after either 'the mailing of the notice of denial,' ORS 656.262(8), or the de facto denial [citing Syphers, supra.]." We note, however, that there was no de facto denial at issue in that case. Hence, we regard the language concerning the timeliness of hearing request from a de facto denial as dicta and not controlling here. Moreover, we are troubled by the court's reliance on Syphers which, as we stated above, says nothing about a limitations period for appealing from a de facto denial.

We are more persuaded by Bebout v. SAIF, 22 Or App 1, aff'd 273 Or 487 (1975). In that case, the SAIF Corporation, acting as processing agent for a noncomplying employer, had actual knowledge of claimant's occupational death claim one or two months after the accident but failed to issue a written denial of the claim until almost two years later. Claimant then filed a request for hearing on the denial within 60 days of the letter. The court held that the hearing request was timely. Id. at 5. We find ample authority for adhering to our previous holding that there is no limitations period for filing a request for hearing on a de facto denial. Accordingly, we conclude that claimant's hearing request in this case was not untimely.

Compensability

Before addressing the issue of compensability, we note the suggestion in the record that this employer may be a noncomplying employer. We have previously held that the issue of noncompliance is generally not necessary to the decision of compensability. Henry C. Adovnik, 36 Van Natta 14 (1984). Whether the employer is complying can be established by a separate order of the Director under ORS 656.052(2), and is not essential to the decision of compensability. Id. at 15. It is a necessary issue only when the question of coverage is raised as a defense to a claim for compensation. Wilfred L. Speckman, 40 Van Natta 2076, 2080 (1988). No such defense is asserted here.

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. Former ORS 656.005(8)(a) (now ORS 656.005(7)(a)). The "arising out of and in the course of employment" language involves the application of a unitary work-connection approach whereby the ultimate inquiry is the same: Is the relationship between the injury and the employment sufficient that the injury should be compensable? Rogers v. SAIF, 289 Or 633, 642-43 (1980). Here, claimant was involved in a motor vehicle accident while driving to Mitchell to perform transmission repairs on a vehicle owned by the employer. Those repairs were made at the direction of the employer. At the time, claimant was employed as a mechanic by the employer. He was receiving an hourly wage plus housing accommodations. We find that the motor vehicle accident on September 11, 1986, was a work-related event. It is undisputed that the motor vehicle accident caused claimant's bilateral leg injury and resulting need for treatment. Hence, we conclude that claimant's injury is work related and, therefore, compensable. See Rogers v. SAIF, supra, 289 Or at 644.

Penalty and Attorney Fee

A penalty and related attorney fee may be assessed

against the employer if the employer unreasonably delays acceptance or denial of a claim. ORS 656.262(10), 656.382(1). Here, the employer never issued a written notice of its acceptance or denial of the claim, and has offered no reasonable explanation for its failure to do so. We conclude that its conduct was unreasonable.

However, a penalty may only be assessed on the basis of amounts of compensation "then due." See ORS 656.262(10); Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162, 164 (1986). Moreover, pending acceptance or denial of a claim, compensation payable to a claimant does not include the cost of medical benefits. See ORS 656.262(6); Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989). Thus, the employer's failure to pay claimant's approximately $11,000 in medical bills cannot form the basis of a penalty.

Yet, the record further establishes that claimant was hospitalized on two occasions and missed a "couple of months" of work as a result of the compensable injury. Consequently, we are persuaded that claimant "left work" because of his compensable injury, thereby entitling him to interim compensation. Accordingly, we assess a penalty in the amount of 25 percent of any amounts of time loss compensation due and owing claimant at the time of hearing. See ORS 656.262(10).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review in ultimately prevailing on the compensability and penalty issues. See ORS 656.386(1); 656.262(10). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded at this time. See id.

ORDER

The Referee's order dated March 10, 1988, is reversed. The employer's "de facto" denial of claimant's bilateral leg injury is set aside and the claim is remanded to the employer for processing according to law. The employer shall pay to claimant a penalty in the amount of 25 percent of any amounts of time loss compensation due at the time of hearing.

ANNA M. TURNER, Claimant	WCB 87-14283
Peter O. Hansen, Claimant's Attorney	November 2, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denials of two claims filed by claimant for a right knee condition. We affirm.

ISSUES

1. Good cause for claimant's failure to request a hearing from the first denial within 60 days.

2. Res Judicata. Whether claimant's failure to appeal

persuaded. The court in Barr, supra, stated that "[a] claimant may request a hearing on a denial within 60 days after either 'the mailing of the notice of denial,' ORS 656.262(8), or the de facto denial [citing Syphers, supra.]." We note, however, that there was no de facto denial at issue in that case. Hence, we regard the language concerning the timeliness of hearing request from a de facto denial as dicta and not controlling here. Moreover, we are troubled by the court's reliance on Syphers which, as we stated above, says nothing about a limitations period for appealing from a de facto denial.

We are more persuaded by Bebout v. SAIF, 22 Or App 1, aff'd 273 Or 487 (1975). In that case, the SAIF Corporation, acting as processing agent for a noncomplying employer, had actual knowledge of claimant's occupational death claim one or two months after the accident but failed to issue a written denial of the claim until almost two years later. Claimant then filed a request for hearing on the denial within 60 days of the letter. The court held that the hearing request was timely. Id. at 5. We find ample authority for adhering to our previous holding that there is no limitations period for filing a request for hearing on a de facto denial. Accordingly, we conclude that claimant's hearing request in this case was not untimely.

Compensability

Before addressing the issue of compensability, we note the suggestion in the record that this employer may be a noncomplying employer. We have previously held that the issue of noncompliance is generally not necessary to the decision of compensability. Henry C. Adovnik, 36 Van Natta 14 (1984). Whether the employer is complying can be established by a separate order of the Director under ORS 656.052(2), and is not essential to the decision of compensability. Id. at 15. It is a necessary issue only when the question of coverage is raised as a defense to a claim for compensation. Wilfred L. Speckman, 40 Van Natta 2076, 2080 (1988). No such defense is asserted here.

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. Former ORS 656.005(8)(a) (now ORS 656.005(7)(a)). The "arising out of and in the course of employment" language involves the application of a unitary work-connection approach whereby the ultimate inquiry is the same: Is the relationship between the injury and the employment sufficient that the injury should be compensable? Rogers v. SAIF, 289 Or 633, 642-43 (1980). Here, claimant was involved in a motor vehicle accident while driving to Mitchell to perform transmission repairs on a vehicle owned by the employer. Those repairs were made at the direction of the employer. At the time, claimant was employed as a mechanic by the employer. He was receiving an hourly wage plus housing accommodations. We find that the motor vehicle accident on September 11, 1986, was a work-related event. It is undisputed that the motor vehicle accident caused claimant's bilateral leg injury and resulting need for treatment. Hence, we conclude that claimant's injury is work related and, therefore, compensable. See Rogers v. SAIF, supra, 289 Or at 644.

Penalty and Attorney Fee

A penalty and related attorney fee may be assessed

against the employer if the employer unreasonably delays acceptance or denial of a claim. ORS 656.262(10), 656.382(1). Here, the employer never issued a written notice of its acceptance or denial of the claim, and has offered no reasonable explanation for its failure to do so. We conclude that its conduct was unreasonable.

However, a penalty may only be assessed on the basis of amounts of compensation "then due." See ORS 656.262(10); Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162, 164 (1986). Moreover, pending acceptance or denial of a claim, compensation payable to a claimant does not include the cost of medical benefits. See ORS 656.262(6); Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989). Thus, the employer's failure to pay claimant's approximately $11,000 in medical bills cannot form the basis of a penalty.

Yet, the record further establishes that claimant was hospitalized on two occasions and missed a "couple of months" of work as a result of the compensable injury. Consequently, we are persuaded that claimant "left work" because of his compensable injury, thereby entitling him to interim compensation. Accordingly, we assess a penalty in the amount of 25 percent of any amounts of time loss compensation due and owing claimant at the time of hearing. See ORS 656.262(10).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review in ultimately prevailing on the compensability and penalty issues. See ORS 656.386(1); 656.262(10). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded at this time. See id.

ORDER

The Referee's order dated March 10, 1988, is reversed. The employer's "de facto" denial of claimant's bilateral leg injury is set aside and the claim is remanded to the employer for processing according to law. The employer shall pay to claimant a penalty in the amount of 25 percent of any amounts of time loss compensation due at the time of hearing.

ANNA M. TURNER, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-14283
November 2, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denials of two claims filed by claimant for a right knee condition. We affirm.

ISSUES

1. Good cause for claimant's failure to request a hearing from the first denial within 60 days.

2. Res Judicata. Whether claimant's failure to appeal

the insurer's May 20, 1987 denial within 60 days precludes her from appealing the insurer's September 28, 1987 denial?

3. Compensability. If claimant is not precluded from appealing the insurer's denials, whether her claim is compensable as either an industrial injury or an occupational disease?

FINDINGS OF FACT

Claimant was employed as a retail sales person. On May 11, 1987, she was examined by Dr. Denker at Kaiser Permanente Hospital for right knee pain. Dr. Denker diagnosed right knee sprain. That same day, claimant filed a claim with the employer for a right knee strain or torn ligaments. She related these problems to an unspecified date in March 1987. She stated on her claim form that she had first noticed knee symptoms during or just before moving fixtures in preparation for a "15-hour sale."

On May 12, 1987, Dr. Denker released claimant for work as of May 14, 1987. He issued a follow-up report on May 18, 1987 indicating that claimant was gradually improving.

On May 20, 1987, the employer issued a denial of the May 11, 1987 claim on the grounds that claimant had failed to give notice of her injury within the time limits established by ORS 656.265. This notice contained a recitation of claimant's appeal rights. The denial was received by claimant on May 23, 1987. Claimant did not appeal the denial at that time.

Claimant returned to regular work. Thereafter, she experienced continuing right knee symptoms.

On September 15, 1987 claimant filed a request for hearing challenging the May 20, 1987 denial. That same date, claimant filed a second claim form with the employer. The claim form referred to claimant's right knee and indicated that claimant's work activities since March had resulted in a need for medical services and disability.

The following day, September 16, 1987, claimant was reexamined by Dr. Denker. He reported that her knee condition was "slightly better." He again diagnosed right knee sprain. He released her to modified work for an estimated two weeks.

By letter dated September 28, 1987, the employer denied the second claim. That denial stated:

> "Our first knowledge of your contended problems was your attorney's letter of September 15, 1987 and an incomplete 801. We have nothing to indicate any injury took place in March 1987. This office previously issued a denial on May 20, 1987 for problems to your right knee. It is unknown if your current contentions are related to the prior denial. This new denial is issued to cover all bases."

On October 1, 1987, claimant filed an amended request for hearing. This request challenged both the May 20, 1987 denial and the September 28, 1987 denial.

Claimant did not request a hearing on the May 20, 1987 denial within 60 days. At hearing, claimant offered no explanation for her failure to request a hearing within 60 days.

CONCLUSIONS OF LAW AND OPINION

We review de novo and independent of the findings and conclusions of the Referee.

Claimant requested a hearing on the employer's May 20, 1987 denial on September 16, 1987. Pursuant to ORS 656.319(1)(a), a request for hearing must be filed within 60 days after the claimant is notified of the denial. Here, claimant admits that her hearing request was not filed within 60 days. Moreover, claimant has offered no evidence supporting a finding that "good cause" exists for her failure to timely request a hearing from the May 20, 1987 denial. See ORS 656.319(1)(b); Naught v. Gamble Inc., 87 Or App 145 (1987). We, therefore, find that we lack jurisdiction to address the merits of that denial.

Claimant did timely request a hearing from the September 28, 1987 denial. The employer nevertheless contends that, pursuant to res judicata principles, claimant's failure to request a hearing on the May 20, 1987 denial precludes her from obtaining a hearing on the September 28, 1987 denial. In addition, the employer argues that claimant may recover only if she proves that she developed a "new" knee condition compensably related to her work exposure. The employer concludes that no evidence supports such a finding.

We turn first to the employer's res judicata argument. The employer argues that claimant's September 15, 1988 claim is barred by application of the doctrine of res judicata because claimant never contested its May 1987 denial. However, the uncontested May 1987 denial only bars further litigation concerning the compensability of claimant's knee condition as it existed in May 1987. See Howard W. Lankin, 35 Van Natta 849 (1983), aff'd mem. 68 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). Consequently, claimant is not precluded from proving any contribution her employment may have had to the worsening or development of her knee condition following the May 1987 denial.

Claimant asserts in this regard that when she returned to work after her first period of disability, her knee was still symptomatic. She further contends that her work exposure resulted in gradually worsening symptoms until she left work the second time. Under the circumstances, we conclude that claimant's second claim is properly analyzed as one of occupational disease for the worsening of a preexisting noncompensable knee condition. See Hollister L. Starr, 39 Van Natta 79, 80-81 (1987). 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 has the burden of proving a pathological worsening of her preexisting condition. Hollister, supra.

Claimant did not sustain that burden. The scant medical record discloses only that claimant continued to experience right knee symptoms in September 1987. The only post-May medical report in the record is the report of Dr. Denker's September 16, 1987 follow-up examination. At that time, Dr. Denker reported increased

pain with deep squat but an otherwise normal examination. Moreover, while claimant testified to increased symptoms, Dr. Denker reported that claimant felt she was "slightly better." We conclude that claimant has failed to prove a worsening of her underlying condition.

Alternatively, claimant argues that her earlier knee condition resolved at some point after returning to work in May 1987. If claimant's knee condition did resolve, such that her symptoms in September 1987 represented a new injury or disease, then claimant need not prove a worsening of a preexisting condition. However, no evidence in the record supports her contention that her prior knee condition had resolved. Instead, the record establishes that claimant's condition did not resolve in May 1987, or at any time thereafter. As of May 11, 1987, Dr. Denker reported that claimant was not medically stationary. On May 18, 1987, Dr. Denker reported that claimant's condition was gradually improving. Moreover, claimant testified that her symptoms "worsened" after May 1987. This statement presupposes existing symptoms rather than an absence of symptoms. We conclude that when claimant returned to work in May 1987 her knee was still symptomatic and that these symptoms continued until she left work in September 1987.

ORDER

The Referee's order dated January 28, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $900.

JOHN VERING, Claimant
Jeff Carter, Claimant's Attorney
Dennis Martin (SAIF), Defense Attorney

WCB 89-10291
November 2, 1989
Order of Dismissal (Remanding)

Reviewed by Board Members Perry and Howell.

Claimant has requested Board review of Referee Michael Johnson's September 29, 1989 order. We have reviewed the request to determine whether we have jurisdiction to consider it. Inasmuch as we conclude that jurisdiction rests with the Hearings Division, this matter is remanded.

FINDINGS

The Referee's order issued September 29, 1989. On October 12, 1989, claimant moved for abatement and reconsideration. On October 24, 1989, the Referee abated his order to permit the SAIF Corporation a reasonable opportunity to respond to the motion. On October 25, 1989, the Board received claimant's request for review, which was mailed by regular mail.

ULTIMATE FINDINGS

The Referee abated his September 29, 1989 order before the Board received claimant's request for review.

CONCLUSIONS OF LAW

Claimant's request for review of the Referee's September 29, 1989 order was filed October 25, 1989, the day it was received by the Board. See OAR 438-15-046(1). Since the Referee's order had been abated prior to the filing of claimant's

request for Board review, jurisdiction to consider this matter rests with the Hearings Division.

Accordingly, the request for Board review is dismissed as premature. This matter is remanded to Referee Michael Johnson for further proceedings.

IT IS SO ORDERED.

DARLENE M. WELFL, Claimant
Eveleen Henry, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0685M
November 2, 1989
Own Motion Determination

The Board issued its Own Motion Order in the above-entitled matter on December 11, 1987, reopening claimant's claim for a worsened condition related to her industrial injury of January 13, 1978. The claim has now been submitted for closure. We close claimant's claim with additional awards of temporary total and permanent total disability benefits.

ISSUES

1. Temporary total disability. When did claimant become medically stationary?

2. Permanent total disability. Does the compensable injury permanently incapacitate claimant from regularly performing work at a gainful and suitable occupation?

FINDINGS OF FACT

Claimant compensably strained her back in January, 1978, while working as a poultry processor. The claim was accepted and first closed by Determination Order on March 31, 1978. After a period of chiropractic treatment, claimant was diagnosed with carpal tunnel syndrome and underwent bilateral carpal tunnel release surgery, followed by repeat sugery on the left carpal tunnel in 1979. Her carpal tunnel symptoms apparently were relieved by surgery.

However, claimant continued to experience symptoms in the neck, upper back and left arm. In 1981 she consulted Dr. Smith, a neurosurgeon. Smith determined that the neck was involved and performed a cervical laminectomy, which relieved claimant's symptoms for almost two years. When her symptoms recurred, Smith performed another cervical laminectomy in 1984, which again relieved her symptoms. Her claim was last closed by Own Motion Determination on August 6, 1985. To date, claimant has been awarded 15 percent scheduled permanent disability for the loss of use or function of the left forearm and 10 percent unscheduled permanent disability.

Claimant's symptoms again recurred in early 1986. Reluctant to undergo further surgery, claimant initially sought chiropractic treatment. However, she returned to Smith in 1987 with headaches, neck and left shoulder pain, and numbness and parasthesias radiating through the left arm. Smith diagnosed cervical spondylosis with nerve root compression at C6-7 and, on September 23, 1987, performed a third cervical laminectomy with nerve root decompression. Claimant's symptoms were significantly relieved.

In February, 1988, claimant developed headaches and radiating pain through her left shoulder, arm and hand. Thereafter,

the symptoms worsened in both frequency and severity. An MRI scan revealed a herniated disc at C6-7. On June 8, 1988, Smith performed a cervical discectomy and interbody fusion at C6-7.

Claimant's permanent impairment due to the compensable back injury and resulting surgeries is moderately severe to severe. She is limited to sedentary to light work with no overhead reaching or repetitive neck movement. She can sit, stand, or walk for only two hours at a time. She also has restrictions on bending, twisting, kneeling, climbing, and repetitive use of the arms, hands and wrists.

Claimant is 47 years of age and has completed the 11th grade. She last worked in 1987. She has prior work experience as a cook, poultry production worker, auto detailer/receptionist and fuel truck driver/clerk. However, she lacks the requisite skills and physical capacities to perform any of those vocations.

FINDINGS OF ULTIMATE FACT

1. Claimant became medically stationary on February 23, 1989.

2. The compensable back injury permanently incapacitates claimant from regularly performing work in a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability

We ordered claimant's claim reopened with temporary total disability benefits to commence on the date of surgery. That surgery was performed on September 23, 1987. Thereafter, she was not released for work until Dr. Smith declared her medically stationary on February 23, 1989. There is no contrary evidence in the record. Accordingly, claimant is awarded temporary total disability benefits from September 23, 1987, through February 23, 1989.

Permanent Total Disability

To establish her entitlement to permanent total disability (PTD), claimant must prove that she cannot regularly perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Here, Smith released claimant for sedentary to light work. Because claimant is not totally incapacitated, she can prevail only by proving that she falls within the so-called "odd-lot" doctrine. Under that doctrine, an injured worker, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of her physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985).

Claimant was referred for vocational assistance in January, 1989. After researching labor market surveys and job analyses, claimant's vocational counselor concluded that claimant could not return to any of her previous occupations or related occupations due largely to their physical and vocational preparation requirements. Most recently, the counselor requested authorization for a training program in accounting clerking/bookkeeping; however, there is no indication that claimant has yet entered a training program. In any

event, claimant's PTD status must be decided on conditions existing at the time of decision, not on any speculative future change in employment status after retraining. See Gettman v. SAIF, 289 Or 609, 614 (1980). We conclude that claimant is entitled to an award of PTD. The PTD award shall be effective as of March 6, 1989, the date of the last vocational rehabilitation report in this record. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, mod 53 Or App 863, 867 (1981). Deduction of overpaid temporary disability, if any, from the PTD award is approved.

IT IS SO ORDERED.

CRUCITA WHITE, Claimant
Peter O. Hansen, Claimant's Attorney
Chelsea Mohnike (SAIF), Defense Attorney

WCB 87-18214
November 2, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of those portions of Referee Mulder's order that: (1) failed to direct the SAIF Corporation to pay her temporary total disability compensation awarded by a Determination Order; and (2) assessed a penalty of $400 for SAIF's failure to pay this compensation. In its respondent's brief, SAIF requests that the Board reverse the Referee's award of 10 percent (32 degrees) unscheduled permanent partial disability for claimant's psychological condition and reverse the penalty assessment. We modify the Referee's order on the temporary disability compensation and penalty issues and reverse the award of permanent partial disability.

ISSUES

1. Whether SAIF should be ordered to pay claimant temporary total disability compensation for the period from November 15, 1985 through July 20, 1987.

2. Whether a penalty should be assessed for SAIF's failure to pay the disputed compensation, and if so, the amount of such penalty.

3. Extent of disability, if any, for claimant's psychological condition.

FINDINGS OF FACT

Claimant began working as a "clinical receptionist" for the employer, North/Northeast Community Mental Health Center, in September 1985. She had applied for a position in the employer's accounting department and did not like working as a receptionist, but took the position hoping to work into an accounting position. During the months following her employment, claimant developed personal conflicts with a number of people with whom she worked. As a result of those conflicts, she quit her job on December 24, 1985.

Claimant was unemployed until late March 1986 when she was hired by another employer as a secretary. She continued in that position until early May 1986 when she was laid off due to poor work performance unrelated to any psychological condition associated with her prior employment. Subjectively, claimant enjoyed her job as a secretary and thought she was doing well at it.

Claimant was unemployed from May through August 1986. From September 1986 to February 1987, she took classes in computer software technology at Oregon Polytechnic Institute. She also worked part time with the City of Portland. In February 1987, claimant experienced medical problems which ultimately required surgery and she had to drop out of school and quit her job with the City of Portland.

On February 7, 1987, claimant filed a workers' compensation claim against the employer in the present case contending that stress associated with her employment had resulted in a mental disorder. SAIF issued a denial of the claim on February 25, 1987. Claimant requested a hearing.

On July 20, 1987, claimant was examined by Dr. Colbach, a psychiatrist, at the behest of SAIF. Colbach had been personally associated with the employer a couple of years before claimant began her employment and reported that there had been "quite a bit of unrest within the agency" at times. Based upon a review of claimant's personal and vocational history, Dr. Colbach diagnosed a personality disorder with passive-aggressive and histrionic tendencies. He thought that claimant probably had experienced stress in the course of her employment with the employer and that this stress temporarily aggravated her underlying personality difficulties for a maximum of three to four weeks. He opined that claimant had become medically stationary in early January 1986 and had sustained no permanent impairment attributable to her employment.

After receiving a copy of Dr. Colbach's report, SAIF rescinded its denial of claimant's claim and issued a single payment of temporary total disability compensation for the period from November 15, 1985 through January 6, 1986. SAIF then submitted the claim for closure and a Determination Order issued on September 8, 1987. The order awarded no permanent disability compensation, but did award temporary total disability compensation for the period from November 15, 1985 through July 20, 1987. SAIF received the Determination Order on September 11, 1987. SAIF requested reconsideration of the order on September 30, 1987 and a second Determination Order issued on October 14, 1987. The second order stated that the first order was incorrect and rescinded the previous award of temporary total disability compensation.

Claimant requested a hearing on the Determination Orders in November 1987 and raised issues relating to permanent disability, temporary disability, penalties and attorney fees.

On January 8, 1988, on referral from her attorney, claimant sought psychological treatment for the first time since leaving work with the employer in December 1985.

A hearing was held on January 19, 1988. On February 22, 1988, the Referee issued an order which awarded claimant 10 percent unscheduled permanent partial disability for her psychological condition, awarded temporary total disability for the period from November 15, 1985 through the day before claimant returned to work in March 1986 and assessed a 25 percent penalty on the compensation awarded by the September 8, 1987 Determination Order. The Referee later amended that portion of the order relating to the penalty to limit the total dollar amount of the penalty to $400.

Claimant was 34 years old at the time of the hearing. She has a GED and two years of college. Before beginning her employment with the employer in September 1985, claimant had numerous short-lived jobs with a variety of employers, primarily in the accounting and data entry areas.

FINDINGS OF ULTIMATE FACT

1. A September 8, 1987 Determination Order awarded claimant temporary total disability compensation from November 15, 1985 through July 20, 1987.

2. The September 8, 1987 Determination Order remained in effect until corrected by an October 14, 1987 Determination Order.

3. SAIF did not comply with the September 8, 1987 Determination Order.

4. SAIF's failure to comply with the September 8, 1987 Determination Order was unreasonable.

CONCLUSIONS OF LAW

Temporary Disability Compensation

The September 8, 1987 Determination Order required SAIF to pay claimant temporary total disability compensation from November 15, 1985 to July 20, 1987. That order remained in effect until it was "corrected" by the October 14, 1987 Determination Order. See ORS 656.268(4); Georgia-Pacific v. Piwowar, 305 Or 494, 504 (1988).

SAIF was required to pay claimant the temporary disability benefits awarded by the September 8, 1987 Determination Order within 14 days. OAR 436-60-150(3)(e); C. D. English, 37 Van Natta 572 (1985). Because it did not do so then, it must now pay that compensation. Claimant's entitlement to that compensation on the merits need not be determined. See Hutchinson v. Lousiana-Pacific, 67 Or App 577, 581 rev den 297 Or 340 (1984).

We note that SAIF could have, but did not, request that the September 8, 1987 Determination Order be abated and reconsidered before its obligation to pay temporary disability compensation matured; that is, within 14 days.

Penalty and Attorney Fee

SAIF offered no reason for failing to pay the temporary disability benefits awarded by the September 8, 1987 Determination Order, other than that the award was wrong. We agree that on its face the Determination Order was inconsistent with the undisputed evidence that claimant had returned to wage earning employment before claim closure. She should have been awarded only temporary partial disability benefits beginning in March 1986 and continuing until claim closure. See OAR 436-60-030(3) & (4).

However, the fact that the award of temporary total disability benefits was incorrect does not explain SAIF's failure to either pay the compensation ordered or to request reconsideration within 14 days. We conclude that SAIF's refusal

to pay compensation pursuant to the Determination Order was unreasonable.

Under the circumstances, we find a penalty equivalent to 10 percent of the temporary total disability compensation ordered paid by the Determination Order and not previously paid to be a proper penalty.

Extent of Disability

The Referee awarded claimant 10 percent (32 degrees) unscheduled permanent partial disability for her psychological condition. We reverse this award because we conclude that claimant has failed to prove that she sustained any permanent impairment as a result of her work activity with the employer.

Claimant's employment history before she began working for the employer consisted of a number of short-lived jobs in fields involving limited personal interaction. She applied for and would have preferred a job in the employer's accounting department. She accepted work as a receptionist despite this preference.

Dr. Colbach, the psychiatrist who examined claimant in July 1987, opined that claimant had sustained no permanent impairment as a result of her compensable injury. He thought that she was psychologically impaired, but that this impairment had preexisted her employment and had not been permanently worsened by it. David Worthington, a psychologist, and Diane Worthington, a Mental Health Specialist, examined claimant in early 1988. They agreed with Dr. Colbach that claimant was psychologically impaired prior to her work for the employer, but thought that the employment had resulted in additional impairment in the minimal range. Claimant testified that she did not believe she could return to work as a clinical receptionist after her experience with the employer. She stated that she would prefer to work in an environment where her interaction with people was limited and she was not closely supervised.

Claimant attempts to attribute her preference for jobs with limited personal and supervisory interaction to her employment experience with the employer. Before beginning that employment, however, her work history reflects a preference for limited personal and supervisory interaction. Indeed, she told Dr. Colbach that she accepted employment with the employer as a receptionist despite an existing preference to the contrary. Given this record, we conclude that claimant has failed to prove that her preference for limited personal and supervisory interaction is attributable to her work activity with the employer and accept Dr. Colbach's opinion that she sustained no permanent impairment.

ORDER

The Referee's order dated February 22, 1988, as amended March 15, 1988, is affirmed in part, reversed in part and modified in part. In lieu of the temporary disability compensation awarded by the Referee, the SAIF Corporation shall pay claimant compensation for temporary total disability for the period from November 15, 1985 through July 20, 1987, less amounts previously paid. SAIF shall also pay claimant a penalty of 10 percent of

this compensation. Claimant's attorney is awarded 25 percent of the compensation granted by this order, not to exceed $3,800. The attorney fee assessed by the Referee on the penalty issue is affirmed. The award of 10 percent (32 degrees) unscheduled permanent partial disability granted by the Referee and the associated attorney fee are reversed.

DOUGLAS K. AINSWORTH, Claimant
Scott M. McNutt, Claimant's Attorney
Cliff, et al., Defense Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-17893 & 87-04346
November 3, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

Industrial Indemnity Company requests review of those portions of Referee Mongrain's order which: (1) set aside its denial of claimant's aggravation claim for his low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility.

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

Industrial Indemnity contends that the Referee failed to give proper legal effect to its May 1986 stipulation arising from a prior aggravation claim following claimant's November 1985 fall at home.

A claimant cannot release rights to future benefits. ORS 656.236(1). The stipulation does not, as Industrial Indemnity contends, eliminate the compensability of claimant's originally accepted low back claim, nor does it preclude subsequent claims under ORS 656.245, 656.273, or 656.278. Furthermore, Industrial Indemnity agreed, as part of the May 13, 1986 settlement, that claimant then had 20 percent permanent, (i.e. continuing), injury-related disability.

Turning to the merits, we are not persuaded that claimant's fall from the fuel tank platform, while working for Liberty's insured, contributed to a worsening of his condition. Thus, we agree with the Referee that responsibility for claimant's current low back condition remains with Industrial Indemnity.

Claimant's brief was rejected as untimely; thus, claimant's counsel is not entitled to attorney fees. See Shirley M. Brown, 40 Van Natta 879, 882 (1988).

ORDER

The Referee's order dated November 20, 1987 is affirmed. A client paid fee, payable from Liberty Northwest to its counsel is approved, not to exceed $483.

JAMES P. BOWERS, Claimant
Brian Whitehead, Claimant's Attorney
Randolph Harris (SAIF), Defense Attorney
Davis, Bostwick, et al., Defense Attorneys

WCB 87-10225, 87-05574 & 87-06625
November 3, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Ebner's order which: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for his current left shoulder condition; (2) upheld Aetna Casualty & Surety Company's aggravation denial of the same condition; (3) upheld Farmers Insurance Company's denial of claimant's "new injury" claim for his left shoulder and psychological conditions; (4) upheld SAIF's denial of claimant's medical services claim for a psychological condition; (5) upheld Aetna's denial of claimant's medical services claim for a psychological condition; (6) declined to assess a penalty and attorney fee against Farmers for an alleged unreasonable denial; (7) affirmed a Determination Order which did not increase claimant's unscheduled permanent disability above the 30 percent (96 degrees) awarded by prior orders and did not increase claimant's scheduled permanent disability for loss of use or function of the left hand above the 30 percent (45 degrees) previously awarded; and (8) declined to assess penalties and related attorney fees for SAIF's alleged late denial of a 1979 aggravation claim. We reverse in part and affirm in part.

ISSUES

(1) Compensability of, and responsibility for, claimant's current left shoulder condition.

(2) Compensability of, and responsibility for, claimant's current psychological condition.

(3) Penalties and attorney fees.

(4) Extent of both unscheduled and scheduled permanent disability.

FINDINGS OF FACT

In August 1975, claimant sustained a compensable injury to his left shoulder while employed by SAIF's insured. The injury was diagnosed as a brachial plexus contusion and traction injury. The injury resulted in winging of the left shoulder, some nerve damage, and partial atrophy, as well as a physical depression in the left shoulder area. The claim was closed by a December 1977 Determination Order, which awarded 15 percent unscheduled permanent disability. An October 1978 Referee's order affirmed the 15 percent unscheduled award and granted a 30 percent scheduled permanent disability award for loss of use or function of the left hand.

In late 1978, claimant began working as a carpenter. In June 1979, Dr. Berselli, orthopedist, reported that claimant had persistent left shoulder and arm discomfort. By a letter dated June 29, 1979, Berselli requested authorization to perform a scapulopexy surgical procedure, which was neither authorized nor formally denied by SAIF. In February 1980, Dr. Berselli advised SAIF that he had no other treatment to recommend to claimant other than surgery. Claimant had been released to work in August 1979.

In July 1982, claimant began working for Aetna's insured. In September 1982, he filed a claim with Aetna for a left shoulder and neck strain. The claim was accepted by Aetna. In June 1983, the claim was closed by a Determination Order. Claimant was awarded temporary disability benefits only. An October 1983 Stipulation affirmed the June 1983 Determination Order.

Thereafter, claimant asserted a worsening of his left shoulder condition and again sought authorization from SAIF for the surgical procedure recommended by Dr. Berselli in 1979. Following SAIF's authorization, Dr. Berselli performed the surgical procedure in January 1984, which involved grafting the scapula to claimant's back. Following the surgery, Dr. Berselli reported that claimant's subjective complaints lessened, but that objective range of motion findings were the same as prior to the surgery. A July 1985 Own Motion Order on Reconsideration affirmed claimant's award of temporary disability benefits and increased his award of unscheduled permanent disability for his left shoulder from 15 percent to 30 percent.

In June 1985, claimant entered a rehabilitation program, under SAIF's claim. The program, which involved training as an autobody mechanic, concluded in October 1986. At the same time, claimant completed a program for an Associate Degree. Thereafter, a February 1987 Determination Order granted claimant temporary disability benefits from June 1985 through October 1986. No change was made to his awards of permanent disability.

In November 1986, claimant began working as an autobody mechanic for another employer. That employment, however, was terminated after a week due to the unavailability of sufficient full-time work. In December 1986, claimant began working as an autobody mechanic for Farmers' insured through a wage-subsidy program. This employment ended on April 4, 1987. On April 6, 1987, claimant sought treatment from Dr. Michels, chiropractor, for his left shoulder. He was released from work from April 6, 1987 through April 20, 1987. Claimant then filed a "new injury" claim with Farmers for his left shoulder condition. On April 15, 1987, Farmers denied responsibility for claimant's claim on the basis that claimant's condition was a continuation of his 1975 injury rather than a "new and separate" injury.

Thereafter, Farmers requested designation of a paying agent pursuant to ORS 656.307. This request was not granted, however, as claimant's aggravation rights on his claim with SAIF had expired. At hearing, Farmers contended that the claim was not compensable. (Tr. 6-9).

In July 1987, claimant was seen by Dr. Mead, psychiatrist, for treatment of depression. In August 1987, Aetna denied claimant's aggravation claim for a psychiatric condition. In September 1987, SAIF denied claimant's aggravation claim for the same condition. In January 1988, Farmers also denied claimant's psychiatric condition.

Claimant was 36 years old at the time of hearing. He has a high school education as well as an Associate degree. He has previously worked as a plumber's helper, carpenter, and autobody mechanic. At the time of hearing, he was working in a job similar to that of an autobody mechanic. He has permanent impairment of the left shoulder in the mildly moderate range.

FINDINGS OF ULTIMATE FACT

SAIF's 1975 compensable injury is a material contributing cause of claimant's current left shoulder condition and psychological condition.

Aetna's 1982 compensable injury did not independently contribute to claimant's current left shoulder or psychological conditions, or their worsening.

Claimant's employment at Farmers' insured did not independently contribute to his current left shoulder condition or his psychological condition, or their worsening.

Farmers' denial of compensability of claimant's left shoulder condition was not unreasonable.

SAIF unreasonably resisted payment of compensation when it failed to formally accept or deny a request for authorization for surgery which was ultimately performed and was reasonable and necessary as it relates to the compensable injury.

As a result of his 1975 compensable injury, claimant has sustained a 30 percent loss of earning capacity.

CONCLUSIONS OF LAW

COMPENSABILITY OF THE LEFT SHOULDER CONDITION

The Referee concluded that claimant's left shoulder condition was not compensable as either a "new injury" or an aggravation. We disagree.

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability and need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987). The compensable injury need not be the sole cause or most significant cause of the need for treatment, but only a material contributing cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987). Accordingly, claimant can establish compensability by establishing that his 1975 industrial injury materially contributed to his current left shoulder condition and need for treatment.

Dr. Manley, orthopedist, diagnosed a frozen left shoulder and a history of left shoulder pathology. He opined that claimant's current condition was a continuation of his 1975 compensable injury. Dr. Michels, claimant's treating chiropractor, opined that claimant's current condition was related to the 1975 injury and the subsequent 1984 surgery. The Orthopaedic Consultants opined that some of claimant's current problems were due to a hysterical conversion reaction. However, they also noted that claimant had left adhesive capsulitis, as well as restricted cervical and parascapular motion, due to the 1975 injury and the 1984 surgery.

The only evidence to the contrary is a report from Dr. Klein, a psychiatrist. She opined that claimant's current symptoms were caused by a hysterical conversion reaction, and that

claimant was "focusing" on his left shoulder injury. Although the Orthopaedic Consultants also diagnosed a conversion reaction, they did not relate claimant's current symptoms entirely to this psychological diagnosis, but noted objective physical symptoms as well. Further, we note that Dr. Klein testified that she did not doubt that claimant has some physical complaints and noted that she was relying on the other physicians in regard to claimant's physical complaints. Given this, as well as the other medical evidence in the record, we are not persuaded by Dr. Klein's opinion.

Accordingly, we conclude that claimant's original injury and the subsequent related surgery remain a material contributing cause of his current disability and need for medical treatment.

RESPONSIBILITY FOR THE LEFT SHOULDER CONDITION

As we have found claimant's left shoulder condition compensable, the issue becomes that of responsibility for the condition. In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court announced that unless work activities at the later employer/insurer independently contribute to the worker's disability (i.e. cause a worsening of the underlying condition) then the worker has sustained a mere recurrence of symptoms and the earlier employer/insurer remains responsible.

The issue of whether claimant's work activities at Farmers' insured worsened his underlying left shoulder condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of the responsibility issue largely turns on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

In March 1985, a CT scan revealed that claimant's fusion was not solid. X-rays taken in September 1986 appeared to show a solid fusion. Dr. Peterson, of the Orthopaedic Consultants, opined that the x-rays were inaccurate in this area and felt it much more likely that there was a nonunion between the scapula and the thorax based on the more accurate 1985 CT scan. Dr. Peterson further opined that there was no objective evidence that claimant's work activities at Farmers' insured caused any left shoulder destabilization.

Dr. Manley opined that claimant's condition had aggravated. He reported that claimant's fusion had become loose, based upon the audible grinding and crunching, but could not say when it loosened. He also noted that he was unfamiliar with this type of fusion surgery and could offer no opinion as to whether the work activity at Farmers' insured caused the fusion to become loose. Dr. Michels opined that claimant's work activity at Farmers' insured aggravated claimant's symptoms, but that the underlying material cause remained the 1975 injury and the post surgical results of 1984.

Under these circumstances, we conclude that claimant's work activities at Farmer's insured did not independently contribute to claimant's current left shoulder condition. In coming to this conclusion, we are most persuaded by the well-reasoned opinion of Dr. Peterson.

Finally, there is no evidence in the record that relates claimant's current disability to the injury sustained while working for Aetna's insured. Accordingly, SAIF remains responsible for claimant's current left shoulder condition.

COMPENSABILILITY OF PSYCHIATRIC CONDITION

The Referee found that claimant's psychological condition was not compensable. We disagree and find claimant's condition compensable not as an occupational disease, but as a consequence of his compensable left shoulder condition.

A claimant asserting the compensability of a psychological condition following an industrial injury must prove by a preponderance of the evidence that the compensable injury was a material cause of the condition, or if the mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen v. Page, 73 Or App 136, 139 (1985); Partridge v. SAIF, 57 Or App 163, 167, rev den 293 Or 394 (1982).

Dr. Mead diagnosed an adjustment disorder with anxiety and depression, secondary to claimant's industrial injuries and their sequalae. At one point, Dr. Mead appears to attribute claimant's present condition to the 1982 injury. However, a full reading of his opinion indicates that he is speaking to the most serious injury to claimant's left shoulder, which occurred in 1975.

Dr. Klein diagnosed a hysterical conversion reaction in which claimant psychologically focused on his injured left shoulder. She opined that the hysterical conversion symptoms were not related to claimant's employment at Farmers' insured. She further opined that the only relationship between claimant's industrial injury and his psychological condition was that the injury provided a focus for the conversion reaction.

We conclude that claimant's 1975 industrial injury and its sequalae is a material contributing cause of his current psychological condition. In reaching this conclusion, we note that Dr. Mead does suggest that claimant's work activities while at Farmers' insured were a material contributing cause to his psychological condition. However, a thorough appraisal of his opinion indicates that he attributes claimant's depression to his physical ailments which we have found to be related to the 1975 compensable injury.

Furthermore, we note that the opinions of both Drs. Mead and Klein support a causal relationship between the 1975 industrial injury and the psychological condition. Cf. Kobayashi v. Suislaw Care Center, 76 Or App 320 (1985). Accordingly, claimant's condition is compensable regardless of whether it is an adjustment disorder or a hysterical conversion reaction. See Karen M. Partridge, 39 Van Natta 137 (1987).

RESPONSIBILITY FOR PSYCHIATRIC CONDITION

As we have previously found that claimant's psychiatric condition is causally related to his 1975 compensable injury, and have further found that claimant's employment with neither Aetna's insured nor Farmers' insured independently contributed to claimant's physical condition, it follows that responsibility for claimant's psychiatric condition rests with SAIF.

In reaching this conclusion, we note that Dr. Mead does suggest that claimant's work activities at Farmers' insured were a material contributing cause to his psychological condition. As noted above, however, Dr. Mead's opinion, on the whole, indicates that he attributes claimant's depression to his physical injuries and the 1984 surgery and his resulting physical limitations.

We further note that Dr. Klein opined that claimant's work for Farmers' insured did not contribute to his psychological condition. Under these circumstances, we conclude that claimant's work at Farmers' insured did not independently contribute to his psychological condition.

PENALTIES AND ATTORNEY FEES

Farmers' Denial

Claimant contends that Farmers' request for an ORS 606.307 order pursuant to ORS 656.307 renders its subsequent denial of compensability at hearing, an unreasonable "back-up" denial. See Bauman v. SAIF, 295 Or 788 (1983). He seeks a penalty and attorney fee. We disagree.

We have previously held that the issuance of a ".307" order precludes a subsequent denial of compensability, absent a Bauman exception. See Judy Witham, 40 Van Natta 1982 (1988). Here, however, no ".307" order issued and we decline to apply the Witham rationale, consequently, we conclude that a request for such an order alone does not preclude a subsequent denial of compensability. Accordingly, we do not find Farmers' denial of compensability to be unreasonable, and a penalty is unwarranted.

SAIF's Response to the 1979 Aggravation Claim

Claimant contends that SAIF unreasonably failed to accept or deny his claim for an aggravation set forth in Dr. Berselli's letter of June 29, 1979. We agree.

In his letter to SAIF, dated June 29, 1979, Dr. Berselli requested authorization for a surgical procedure and stated inter alia:

> "I think that at this time, the patient's condition is not medically stationary. I think it has worsened since claim closure, and I think that surgical treatment is definitely indicated."

Although SAIF did not authorize this surgery, it did not formally deny either surgery or a reopening of claimant's claim. Although the thrust of Dr. Berselli's letter speaks to the surgical procedure, he clearly indicates that additional medical services were necessary. Accordingly, SAIF had a duty to either accept or deny the claim in a timely fashion. It did not do so, rather, it took no action and has offered no justification for its failure to process the claim. Under these circumstances we find that SAIF unreasonably referred to timely deny claimant's aggravation claim. ORS 656.262(10).

Despite SAIF's unreasonable conduct, the record does not establish that there are any "amounts then due." A penalty for an unreasonable or refusal to issue a denial, as here, would be

assessed on the amounts due at the time of hearing. Roger G. Prusak, 40 Van Natta 2037 (1988). Cf. Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988). Here, the requested surgery was in fact performed in 1984 and paid for by SAIF at that time. Accordingly, it was not an amount then due at the time of the hearing.

Further, there is no evidence that claimant missed any work, due to the worsening, during this time period nor that time loss was authorized. See ORS 606.773(6). Accordingly, there is no disability compensation on which to base a penalty. Bono v. SAIF, 298 Or 405 (1984). No penalty may be assessed.

Nevertheless, an attorney fee can be awarded, and we find it appropriate to do so in this instance. We find that SAIF's failure to take action on claimant's request for reopening and surgery to be unreasonable resistance to the payment of compensation. See Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). In this regard, we note that the insurer delayed in authorizing surgery that was ultimately compensable.

EXTENT OF PERMANENT DISABILITY

The Referee affirmed the February 1987 Determination Order, which did not increase claimant's permanent disability above the 30 percent scheduled permanent disability for loss of use or function of the left hand and the 30 percent unscheduled permanent disability as awarded by prior orders. We agree.

Pursuant to ORS 656.278(5), claimant is entitled to a new determination of his permanent disability following completion of an authorized training program. Hanna v. SAIF, 65 Or App 649 (1983). Further, the new determination is made without regard to the previous awards. Watkins v. Fred Meyer, Inc., 79 Or App 521 (1986).

Unscheduled Permanent Disability

At the outset, it is necessary to discuss claimant's psychological claim and its relationship to rating claimant's unscheduled permanent disability. We have found the psychological condition compensably related to claimant's 1975 injury; therefore the psychological condition claim is one for an aggravation under own motion as wellas a claim for medical services. However, claimant's aggravation rights have expired and there is no evidence suggesting that the psychological condition is medically stationary. If claimant was not medically stationary at the time of hearing, claimant is entitled to be rated based on the facts and circumstances existing at the time he was last medically stationary, i.e. prior to the worsening of claimant's injury related condition. Pauline Travis, 37 Van Natta 194 (1985), reversed and remanded on other grounds, Travis v. Liberty Mutual Ins. Co., 79 Or App 126 (1986).

Given that claimant's psychological condition was not medically stationary at the time of hearing, we rate claimant's permanent disability at the time he was last medically stationary. Claimant was taken off work as of April 6, 1987 for his injury related physical and psychological difficulties. Accordingly, we find it appropriate to rate claimant's disability prior to this time as it is the last date he was medically

stationary. Therefore, claimant's psychological condition is not considered in rating unscheduled permanent disability.

In rating the extent of claimant's unscheduled permanent disability, we consider his permanent physical impairment, which reflects credible lay testimony concerning his disabling pain, and all relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

The Referee made specific findings regarding claimant's lack of credibility. She found his testimony confusing and inconsistent with prior histories he had given to various doctors. To the extent this finding is based on demeanor, we will defer to the Referee. Where, however, the Referee's finding on credibility is based on an objective evaluation of the substance of the witnesses testimony, the Referee is in no greater position to make an assessment on credibility than is the Board. Davies v. Hanel Lumber Co., 67 Or App 35 (1984).

In this matter, based in part on her finding on demeanor, and our review of the record, we agree that claimant's testimony was inconsistent with prior statements. Consequently, we place less weight on claimant's statements regarding his physical restrictions and limitations.

After reviewing the medical and lay evidence, and considering the aforementioned guidelines, we agree with the Referee that a 30 percent unscheduled permanent disability award adequately compensates claimant for his compensable shoulder injury. In reaching this conclusion, we rely in part on the Orthopaedic Consultants' report, which indicated that claimant's impairment remained mildly moderate and on the fact that he has recently completed a two year program at the community college which has increased the size of the job market available to him.

Scheduled Permanent Disability

The criteria for rating scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining loss of use or function, we consider medical and credible lay evidence in light of the rules set forth in former OAR 436-30-001 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See SAIF v. Baer, 61 Or App 335, 337-38, rev den 294 Or 749 (1983).

As noted in our discussion above of claimant's unscheduled disability, we give little weight to claimant's testimony regarding his physical restrictions and limitations. However, the medical evidence does indicate that claimant experiences a permanent loss of grip strength as well as permament numbness in his left hand as a result of the compensable injury and the subsequent surgery. Accordingly, we agree that a 30 percent scheduled permanent disability award for loss of use or function of the left hand adequately compensates claimant.

ORDER

The Referee's order dated July 13, 1988 is reversed in part and affirmed in part. That portion which upheld the SAIF

Corporation's 1987 denial of claimant's medical services claim is reversed. SAIF's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on Board review concerning this issue, claimant's attorney is awarded a reasonable fee of $3,000, payable by SAIF. In addition, claimant's attorney is awarded a reasonable fee of $250 concerning SAIF's untimely denial of claimant's 1979 aggravation claim, also payable by SAIF. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,574 is approved, payable by Aetna to its counsel. A client-paid fee, not to exceed $1,010.30 is approved, payable by Farmer's to its counsel.

ELVA M. PIERCE, Claimant
Charles D. Maier, Claimant's Attorney
Gary T. Wallmark (SAIF), Defense Attorney
Williams, et al., Defense Attorneys

WCB 87-09612, 86-14256, 86-14503 & 86-14504
November 3, 1989

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation requests review of Referee Michael Johnson's order which found it responsible for claimant's current cervical and shoulder condition, and which awarded claimant an insurer-paid fee of $1100. The issues on review are responsibility and attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable left shoulder and neck injury on December 10, 1981, while working for the employer, Salem Hospital. The diagnosis was probable mild strain to the left shoulder. Later, a herniated C5-6 disc was diagnosed. The SAIF Corporation accepted the claim as a nondisabling injury on February 18, 1982.

On June 11, 1984, claimant's injury related condition aggravated while she was in the hospital for unrelated surgery. The diagnosis was a herniated disc at C5-6. Her SAIF claim was reopened and time loss was authorized beginning June 25, 1984.

On August 16, 1984, Drs. Shaw and Buza performed an anterior cervical discectomy and fusion. Claimant had a good recovery from surgery, but still had pain, tingling, and numbness in her thumb and fingers, muscle spasms in her shoulder and headaches.

On October 1, 1984, Liberty Northwest assumed the employer's Workers' Compensation coverage. Dr. Shaw released claimant to return to modified work in November, 1984, and to regular work as of December 14, 1984. He declared her medically stationary on March 22, 1985. An April 29, 1985 Determination Order granted claimant 20 percent unscheduled permanent partial disability and 5 percent scheduled permanent partial disability for loss of the left hand.

Claimant returned to full time work in March, 1985. She continued to work until April 15, 1986, when she voluntarily resigned, stating on her written resignation that she could not work the 11-7 shift and that she was unable to sleep well during the day. She later told physicians that she terminated her employment because her symptoms had worsened and she was unable to tolerate the increased pain.

On May 28, 1986, claimant returned to Dr. Shaw, whom she had not seen for more than a year, complaining of a marked increase in symptoms in the left arm, which she stated had been increasing since January, 1986. On June 25, 1986, Dr. Buza reported that claimant had had left arm pain since January, 1986, and that the symptoms began to increase in intensity since April 1, 1986.

A July 12, 1986 CT scan showed no objective change in claimant's shoulder condition since she had last seen Dr. Shaw for her closing exam in 1985.

Claimant filed an aggravation claim with SAIF and a "new injury" claim with Liberty Northwest. SAIF issued a denial of responsibility on August 20, 1986, Liberty Northwest denied responsibility on September 9, 1986. An order pursuant to ORS 656.307 issued on September 30, 1986, designating SAIF as the paying agent. Claimant retained the services of an attorney on March 10, 1987.

Claimant was referred to the Salem Hospital Industrial Medicine program. On initial medical evaluation, no physical basis for her symptoms was found, and the examiners felt that psychological factors accounted for virtually all of claimant's functional limitations. On psychological evaluation, Dr. Davis, a clinical psychologist, agreed that there was no objective basis for claimant's complaints. He felt that she suffered a personality disorder, unrelated to her injury, which caused her pain problem. He felt that her ties with the compensation system were reinforcing her psychopathology.

On May 13, 1987, Dr. Shaw indicated his concurrence.

Dr. Shaw was deposed on August 27, 1987. He explained that he based his opinion that claimant's symptoms had worsened on the history claimant presented to him. He did not dispute that claimant was actually feeling the symptoms she reported, but he felt that her symptoms were exaggerated and that there were no objective findings to support a worsening of her pathological condition.

Claimant's total disability compensation rate under his Liberty Northwest claim is greater than the rate under his SAIF claim.

CONCLUSIONS OF LAW

Responsibility

In order to shift responsibility for claimant's current condition from SAIF, the earlier insurer, to Liberty, the subsequent insurer, there must be a showing that claimant's underlying condition has worsened and that the work activities while Liberty was on the risk independently contributed to that worsening. Hensel Phelps Construction Co. v. Mirich, 81 Or App 290 (1986). We find that there has not been a worsening of claimant's underlying condition and conclude that responsibility remains with SAIF.

SAIF points to the Referee's express credibility finding, contending that claimant is truthful in her complaints of increased pain, and, therefore, her condition has worsened. The

Referee does not provide the basis for his credibility finding. We interpret it, however, to mean that he believed claimant was honest and sincere in her testimony and statements to her physicians.

We do not find the credibility of claimant to be the dispositive issue here. Claimant may be sincere in her complaints of increased pain beginning in January or April of 1986. The question is whether or not the history and pain complaints presented to various physicians present a reliable basis upon which they founded there opinions. We find that her statements do not present a reliable or sufficient basis upon which to infer a worsening of claimant's injury related condition.

Dr. Shaw explained at deposition how a worsening of symptoms could indicate a worsening of the underlying condition. He admitted that, as her treating physician, he believed her complaints of increased pain were valid. However, as time went on, he began to question whether the source of the complaints was physical, so as to indicate a worsening of the pathology, or psychological. He concluded, as did the physicians at the Industrial Medicine Program, that there was no objective basis for claimant's increased complaints, and that claimant's symptoms were exaggerated.

We are persuaded by the opinions of the Industrial Medicine physicians and of Dr. Shaw, and we find that the basis for claimant's increased symptoms was psychological rather than physical and that there has been no worsening of the underlying injury related pathology. We conclude, therefore, that SAIF remains responsible for claimant's current condition.

Attorney Fees

A claimant's attorney is entitled to a reasonable carrier-paid fee if claimant prevails finally in a hearing before a Referee in a "rejected case." ORS 656.386(1). A "rejected case" is a case in which claimant's entitlement to receive compensation, as opposed to the amount of compensation or extent of disability, is at issue. Short v. SAIF, 305 Or 541, 545-46 (1988).

Here, claimant's entitlement to receive compensation was resolved prior to the hearing through the issuance of a .307 order. See former ORS 656.307(1); Hunt v. Garrett Freightliners, 92 Or App 40, 42 (1988); Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). Therefore, upon the issuance of the .307 order, compensability was not at issue. Accordingly, no fee may be awarded for services at hearing regarding the compensability issue.

In addition, claimant contended that Liberty Northwest is the responsible insurer. Inasmuch as that position has not prevailed, claimant would not be entitled to a fee under ORS 656.386(1). See Petshow v. Farm Bureau, Inc., 76 Or App 503 (1983); Donald D. Davis, 40 Van Natta 2000 (1988). Moreover, since claimant did not retain counsel until after the .307 order had issued, there is no basis for awarding an attorney fee under ORS 656.386(1) for services rendered in securing claimant's entitlement to compensation. See Donald D. Davis, supra.

Finally, a claimant's attorney is entitled to a carrier-paid fee for services rendered on review if a carrier

requests review and the Board determines that claimant's compensation "should not be disallowed or reduced." ORS 656.382(2). Here, as a result of our decision, claimant's compensation has been reduced because the carrier with the lower temporary disability compensation rate, SAIF, has been found responsible. Under such circumstances, claimant is not entitled to a fee under ORS 656.382(2).

ORDER

The Referee's order dated December 3, 1988, as amended January 13, 1988, is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. SAIF shall reimburse Liberty Northwest for its claim costs incurred to date. A client-paid fee, not to exceed $269.50, payable from Liberty Northwest to its counsel, is approved.

HIPALITO SUAREZ, Claimant — WCB 87-02110
Emmons, et al., Claimant's Attorneys — November 3, 1989
Cummins, et al., Defense Attorneys — Order on Reconsideration

Reviewed by Board Members Speer and Howell.

Claimant requests reconsideration of that portion of our October 10, 1989 Order on Review that declined to address the issue of the reasonableness and necessity of claimant's current chiropractic treatments. Specifically, claimant asserts that the reasonableness and necessity of his current treatment was precisely the issue raised by the insurer's partial denials of his further chiropractic care.

Pursuant to our order, we affirmed the Referee's order which had set aside the insurer's partial denials of "further chiropractic care." However, we disagreed with the Referee's reasoning. Rather than addressing the merits of the denials as the Referee had done, we concluded that the insurer's partial denials were procedurally improper. Specifically, we reasoned that the denials denied "further chiropractic care." As such, we held that they were purely prospective and, therefore, invalid. See Robert M. Bryant, 41 Van Natta 324 (1989).

In addition, since there were no denied medical services claims in the record and because neither party had raised the issue of the frequency of treatments, we held that the Referee's ruling concerning the frequency of claimant's treatments had been gratuitous and improper. Consequently, we expressed no judgment concerning the reasonableness and necessity of claimant's current chiropractic treatment.

Claimant contends that the question of the reasonableness and necessity of his current treatment was precisely the issue raised by the insurer's August 17, 1987 denial. We acknowledge that a portion of the insurer's denial characterizes its January 14, 1987 denial as a denial of "reasonableness and necessity of current chiropractic treatment." Yet, each denial expressly provides that the insurer is denying "further chiropractic treatment" or "further chiropractic care." Moreover, as noted in our prior order, no denied medical services claims are present in this record. Consequently, because there is no denied claim for current chiropractic treatment in this record, we continue to conclude that neither the Referee nor the Board has

jurisdiction to consider the issue of the reasonableness and necessity of claimant's current treatment. Quite simply there was no disputed treatment with respect to which a determination of reasonableness and necessity could be made.

Accordingly, the request for reconsideration is granted and our October 10, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 10, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

DOROTHY VIROSTKO, Claimant
Bullard, Korshoj, et al., Defense Attorneys

WCB 87-13469
November 3, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant, pro se, requests review of Referee Leahy's order that dismissed her request for hearing on the self-insured employer's denial of her occupational disease claim for right wrist tenosynovitis as untimely filed. On review, claimant contends that the hearing request was timely. We agree and reverse.

ISSUES

1. Timeliness of claimant's hearing request.

2. Compensability of right wrist tenosynovitis.

3. Penalty and attorney fee for allegedly late and unreasonable denial.

FINDINGS OF FACT

We adopt the findings of fact in the first and second paragraphs of the "FACTS" portion of the Referee's order with the following supplementation. Claimant treated with Dr. Custis and Dr. Graham. The eventual diagnosis was tenosynovitis (de Quervain's) of the extensor pollicis brevis and abductor pollicis longus of the right arm. Claimant has lost no time from work due to this condition.

The employer received notice or knowledge of claimant's occupational disease claim for right wrist tenosynovitis on January 7, 1987. The employer denied the compensability of the claim by letter dated June 25, 1987. There was no medical evidence in support of the denial. The denial letter was mailed on or after June 30, 1987. Claimant received the letter sometime between July 1 and 3, 1987.

Claimant filed a request for hearing on the denial on August 31, 1987. At hearing, claimant raised the issues of compensability and penalties and attorney fees for the allegedly late and unreasonable denial. The Referee gave the parties a full opportunity to develop the record on all three issues at hearing.

FINDING OF ULTIMATE FACT

Claimant's work activities contributed more to the onset

of her wrist condition than all other activities or exposures combined.

CONCLUSIONS AND OPINION

Timeliness of Hearing Request

The Referee dismissed the hearing request, finding that the request was not timely filed within 60 days of the denial date and that claimant lacked good cause for failing to do so. We disagree and, instead, find that the hearing request was timely filed.

There are two statutory provisions that prescribe the limitations period for filing a request for hearing on a denial of a claim for compensation. In relevant part, ORS 656.262(8) provides that a claimant may request a hearing on the denial at any time "within 60 days after the mailing of the notice of denial." (Emphasis added). ORS 656.319(1)(a) provides that a request for hearing on a denial must be filed within 60 days after the claimant is "notified of the denial," unless good cause for failure to file within that time is shown. The courts have interpreted "notified" to mean deposited in the mails. Norton v. Compensation Department, 252 Or 75, 78 (1968); Madewell v. Salvation Army, 49 Or App 713, 715 (1980). That interpretation is consistent with former OAR 438-05-065, which provided that notice of a denial shall be in writing and "should in every case be delivered by registered or certified mail with return receipt requested" or by personal service. See Madewell v. Salvation Army, supra. Compliance with that rule provided a record of the mailing date.

Here, there is no indication that the denial letter was delivered by registered or certified mail or by personal service. Indeed, the employer offered no proof of the mailing date. Although the denial letter is dated June 25, 1987, there is no presumption that a letter was mailed on the day it is dated or on the day it was written. Id. Consequently, the only available proof of mailing is claimant's testimony that she received the letter sometime between July 1 and 3. Given that, if we were to assume that the mailing date was June 30, 1987, the last day of the 60-day limitations period would have been Saturday, August 29. The limitations period would then have run until Monday, August 31. Former OAR 438-05-040(4)(c). In that event, claimant's hearing request, which was filed on August 31, 1987, would have been timely. In order to conclude that her request was not timely, we would have to find that the denial letter was mailed before June 30. However, there is no proof to support that finding. We conclude, therefore, that claimant timely filed her hearing request, giving the Hearings Division jurisdiction to hear her case.

Given our disposition of the timeliness issue, we may remand to the Referee for further evidence taking, correction or other necessary action if we determine that this case has been "improperly, incompletely or otherwise insufficiently developed or heard" by the Referee. ORS 656.295(5). In his order, the Referee noted that all of the evidence offered by both parties had been received. After reviewing the record, we are satisfied that both parties had an adequate opportunity to present evidence on the substantive issues in this case and that the record on review is complete. Therefore, remand is not warranted.

Compensability

To establish a compensable occupational disease claim, claimant has the burden of proving that her work activities were the major contributing cause of either the onset or the worsening of her right wrist condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). "Major contributing 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, 166 (1983); Dethlefs v. Hyster Co., supra, 295 Or at 309-10; Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987).

The only medical evidence on compensability was generated by Drs. Graham and Custis, the treating physicians. Both physicians diagnosed right wrist tenosynovitis, though Custis' diagnosis included a ganglion cyst. Graham opined that claimant's continual and repetitive use of the keyboard and punchpad at work was "the major contributing factor" in causing her wrist condition. In the absence of contrary medical evidence, we find that work activities contributed more to the onset of the wrist condition than all other activities or exposures combined, and thus conclude that they were the major contributing cause of the condition. Claimant's occupational disease claim is compensable.

Penalty and Attorney Fee

Claimant contended both at hearing and on review that the employer's June 25, 1987 denial was both late and unreasonable. The employer responded at hearing that the issue was not properly before the Referee because it was not specifically raised in claimant's hearing request. We disagree with the employer. In her hearing request, claimant raised a general objection to the denial. She later clarified her objection at hearing, raising the issues of compensability and penalties and attorney fees. Resolution of the latter issue involves essentially the same evidence offered on the compensability issue. Consequently, we are satisfied that the employer had an adequate opportunity to defend against both issues. We conclude, therefore, that the penalties and attorney fees issue was properly before the Referee and is properly before us on review.

A penalty is assessed if the employer unreasonably refused to pay compensation or unreasonably delayed acceptance or denial of a claim. ORS 656.262(10). The penalty may be assessed up to 25 percent of the "amounts then due." Id. Here, the record is devoid of evidence to support the denial. Indeed, both physicians agreed that claimant's condition was work related. Dr. Graham's opinion, in particular, was persuasive. Under these circumstances, we conclude that the employer had no legitimate doubt of its liability. Hence, the denial was unreasonable. See Peterson v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986).

We further conclude that the June 25, 1987 denial was unreasonably late. ORS 656.262(6) provides that written notice of acceptance or denial must be furnished to claimant within 60 days after the employer has notice or knowledge of the claim. Here, the employer issued the denial more than five months after receiving notice or knowledge of the claim in January 1987 and offered no explanation for the delay.

Because the denial was unreasonable as well as late, a penalty may be assessed against amounts of compensation due at the time of hearing. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). Claimant lost no time from work; therefore, no amounts of interim or temporary disability compensation were due. Although the record shows that medical services were rendered here, a penalty may not be assessed against such services pending acceptance or denial of the claim. See Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989). But see Whitman v. Industrial Indemnity Co., 73 Or App 73, 77-78 (1985). Absent any amounts of compensation "then due," we may not assess a penalty here.

ORDER

The Referee's dismissal order dated January 15, 1988 is reversed. Claimant's August 31, 1987 hearing request is reinstated. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law.

CLEO I. BESWICK, Claimant
W.D. Bates, Jr., Claimant's Attorney
H. Thomas Andersen (SAIF), Defense Attorney

WCB 86-00108
November 6, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Young's order that granted claimant permanent total disability in lieu of an award by Determination Order of 25 percent (80 degrees) unscheduled permanent partial disability for a neck injury. The issue on review is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury has resulted in a functional element which renders her severely impaired.

Considering claimant's severe impairment and her age, it would be futile for her to seek work.

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

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

SAIF's primary argument on review is that the severity of claimant's complaints is "highly questionable." SAIF thereby implies that claimant either intentionally or unintentionally exaggerates the degree and/or duration of the symptoms of her compensable injury

We are not persuaded that claimant consciously exaggerates the severity or duration of her symptoms. Dr. Lechnyr reported no tendency on claimant's part to "over-evaluate" her symptoms. Dr. Paxton reported that claimant's pain was real. Although he found no objective basis for claimant's continued symptoms, Dr. Mead reported that, by history, claimant's complaints and symptoms do relate to her December 1984 injury.

On the other hand, claimant was diagnosed at the Injured Workers' Program as suffering from functional overlay. Dr. Paxton has reached the same conclusion. Therefore, there does appear to be a functional element to claimant's condition. An injury manifests a functional element when a claimant continues to experience pain and discomfort after the structural causes of an injury are no longer apparent. Barrett v. Coast Range Plywood, 294 Or 641 (1983). Disability caused by a functional element resulting from a compensable injury is no less compensable than disability resulting from pathological causes. Mesa v. Barker Manufacturing, 66 Or App 161 (1983).

We conclude that:

> "[w]hether claimant's pain is organic or functional, it is nevertheless real, disabling, beyond [her] control, and unlikely to stop." Elliot v. Precision Castparts, 30 Or App 399, 401, rev den 280 Or 171 (1977).

We further find that, given claimant's severe restrictions, any part time employment satisfying those restrictions would not be "regular" or "gainful" employment under either ORS 656.206(1) or (4). Attempts to obtain regular gainful employment would be futile.

Accordingly, we find that claimant is unemployable on a regular basis in a hypothetically normal labor market. She is, therefore, entitled to an award of permanent total disability.

ORDER

The Referee's order dated February 16, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $750, payable by the SAIF Corporation.

ALBERT HUNTLEY, Claimant
Peter O. Hansen, Claimant's Attorney
Spears, et al., Defense Attorneys

WCB 87-08552
November 6, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Zucker's order which: (1) upheld the self-insured employer's partial denial of attendant care; (2) assessed a penalty and associated attorney fee for late payment of attendant care and automobile equity; and (3) declined to address the issue of reimbursement for equity in claimant's automobile pursuant to principles of res judicata. The issues on review are medical services, penalties and associated attorney fees, and res judicata. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Opinion with the following supplementation on the attendant care reimbursement issue.

In our previous order, Albert Huntley, 39 Van Natta 120 (1987), we stated that claimant was required to submit bills for attendant care "he actually uses." Moreover, former OAR 436-10-090(1) requires that "[a]ll* billings shall be fully itemized and services identified by code numbers and descriptions * * *." In this case, there are no code numbers, since the attendant care is not being given by a licensed professional. However, itemizing and describing the services and time it takes to perform them is required by the rule. We, therefore, conclude that claimant has neither abided by our prior order nor the applicable administrative rules.

ORDER

The Referee's order dated April 22, 1988 is affirmed. A client-paid fee, payable from the employer to counsel, not to exceed $2,600, is approved.

EDWARD A. McCALLISTER, Claimant	WCB 88-01017
Francesconi & Associates, Claimant's Attorneys	November 6, 1989
Gail Gage (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Brazeau's order that set aside its denial of claimant's mental stress claim. Claimant did not timely file his respondent's brief. The issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

FINDINGS OF ULTIMATE FACT

Claimant experienced a mental disorder in the form of an adjustment disorder commencing in September 1987. Claimant's job change from laundry truck driver to dormitory housing supervisor was the major cause of that adjustment disorder.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's mental disorder was compensable as an industrial injury. SAIF contends on review that claimant's condition should be analyzed as an occupational disease rather than as an injury. We do not agree. We adopt the Referee's Conclusions and Opinion in this regard. However, even if we were to agree with SAIF's characterization of the issue, we would conclude that claimant has established the compensability of his condition as an occupational disease.

In order to establish a compensable occupational

disease, claimant must prove that his work was the major cause of the development or worsening of his mental disorder. See McGarrah v. SAIF, 296 Or 145 (1983). Claimant's treating physician, Dr. Mead, opined that claimant's work was the major cause of his disorder. Dr. Holland, an independent medical examiner, opined that claimant's non-vocational stressors would have been more stressful to the average person than vocational stressors. However, the test is how the stressors affected this worker. Peterson v. SAIF 78 Or App 176 (1986); Dr. Holland's test results tend to support Dr. Meade's conclusion.

Claimant has proven the compensability of his claim under either an injury or an occupational disease theory.

Claimant has successfully defended against a carrier-initiated request for review attempting to disallow his compensation. Claimant's attorney would normally be entitled to an assessed fee for his services on Board review. See ORS 656.382(2). However, claimant did not timely file a brief. Moreover, there is no evidence in the record that claimant's counsel provided legal representation short of briefing which would support an attorney fee award on review. See Dan W. Hendrick, 38 Van Natta 208 (1986), aff'd mem 83 Or App 275 (1987). We conclude that claimant's counsel is not entitled to the award of an assessed fee on review. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated April 22, 1988 is affirmed.

STEWART E. MYERS, Claimant
Karen M. Werner, Claimant's Attorney
Gleaves, et al., Defense Attorneys

WCB 87-15645
November 6, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Huffman's order that upheld the insurer's denial of his claim for a respiratory condition. On review, claimant asserts that his claim is compensable. In the alternative, he requests that his case be remanded to the Referee for the taking of additional evidence. We deny the request for remand and affirm on the merits.

ISSUES

1. Remand.

2. Compensability.

FINDINGS OF FACT

Claimant, 34 years of age at hearing, has worked since at least 1971 in a number of trades which potentially exposed him to a variety of occupational chemicals and irritants. His employment during the period from 1971 to 1980 was in the boat industry in the state of Washington. During this period of time, claimant experienced periodic chest tightness and shortness of breath.

In approximately 1981, claimant moved to Grants Pass, Oregon. This move resulted from his physician's recommendation that he discontinue his work and go to a drier climate. From 1981 through 1985, claimant's work activities included logging, truck driving, commercial fishing, and additional work in the boat industry. His symptoms decreased during this period without completely disappearing.

In approximately May 1985, claimant commenced work at Country Camper, where his main activities involved camper body repair work. He worked at Country Camper for about 9 months. He experienced no marked increase in symptoms while so employed.

Claimant was unemployed between January and July 1986.

In July 1986, claimant commenced work with the insured. The insured builds and repairs motor homes. Claimant's primary job duties involved work with fiberglass. Claimant also performed occasional "touch-up" paint jobs. The paint which was used contained isocyanates. All painting was performed in specially constructed paint booths, exhaust from which was filtered and channeled to outside the building. These were new booths which were installed prior to claimant commencing work with the insured. Masks with charcoal filters were available for use by all employees.

While employed by the insured, claimant experienced increased chest pain, light-headedness and cough. On at least two occasions, claimant experienced episodes of near loss of consciousness. Claimant did not seek medical attention for these problems.

In April 1987, claimant was laid off from his job. At the time, he was incarcerated in the county jail for a probation violation. Claimant's original offense was related to the use of intoxicants. While employed by the insured, claimant consumed a fifth or more of alcohol per week. Claimant missed work as a result of his use of alcohol. Claimant did not return to work after April 1987. He was fired from his job in June 1987.

On July 29, 1987, claimant filed an occupational disease claim with the insurer.

Claimant was examined by Dr. Jansen, an occupational medicine specialist, on August 3, 1987. Dr. Jansen performed pulmonary tests which returned normal results. Noting inconsistencies in claimant's reported history, Dr. Jansen requested that claimant provide her with an exact chronology of his prior employments, as well as a list of the chemicals to which he had been exposed. Shortly thereafter, claimant provided Dr. Jansen with an incomplete list of the chemicals with which he had worked. By letter dated September 10, 1987, claimant's attorney requested that claimant provide Dr. Jansen with a more complete list of his prior chemical exposures.

In October 1987, claimant changed residences. Claimant did not receive his mail following this move until approximately mid-December 1987.

Claimant smokes approximately one pack of cigarettes per day and has done so for the past twelve years.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant asserts that a postal "mix-up" interfered with his ability to develop his case. Specifically, claimant alleges that he did not receive his mail for two months and, therefore, did not receive correspondance from his attorney or his physician. The evidence which claimant seeks to include in the record consists of chart notes and a report from a consulting physician who first examined claimant post-hearing. Should the matter be remanded, claimant also proposes to consult with additional physicians with regard to his condition.

We may remand a case to the Referee for further evidence taking if we determine that the case has been improperly, incompletely or insufficiently developed. ORS 656.295(5). Remand, however, is generally appropriate only upon a showing of good cause or another compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). If evidence was obtainable with the exercise of due diligence prior to hearing, remand is generally not appropriate. See Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Claimant filed his claim with the insurer on July 29, 1987. He first consulted with Dr. Jansen in early August 1987. Hearing on his claim was held approximately six months later, on Juanuary 27, 1988. Even accepting his testimony that he did not receive his mail for approximately two months as a result of the error of postal authorities, he nevertheless had sufficient opportunity to cooperate with Dr. Jansen in the preparation of his case. Moreover, after filing his claim and hearing request, claimant had an affirmative duty to aid in the preparation of his case for hearing. Under the circumstances, his failure to maintain contact with either his attorney or his treating physician for more than two months cannot be used as grounds for remand.

We conclude that claimant failed to exercise due diligence in obtaining the evidence for which he seeks remand. With the exercise of due diligence, the evidence claimant seeks to have included in the record could have been obtained prior to hearing. Consequently, his request is denied.

Compensability

To prevail on his occupational disease claim, claimant must demonstrate that his work exposures, when compared to his nonwork exposures, were the major cause of the onset or worsening of his respiratory condition. See former ORS 656.802(1)(a); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985). Here, claimant's respiratory difficulties preexisted his employment with the insured. Consequently, he must prove that his work exposures were the major cause of a worsening of his underlying condition resulting in disability or a need for medical services. Weller v. Union Carbide Corp., 288 Or 27 (1979).

Claimant's respiratory condition has not been definitively diagnosed. Dr. Jansen has posited that his condition is either airway irritation or asthma. Dr. Jansen is unable to offer any explanation for claimant's episodes of near loss of consciousness. The lack of a definitive diagnosis does not per se

defeat the claim. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988) (knee condition of uncertain etiology found compensable). However, the causation issue, as opposed to the question of diagnosis, must be resolved. Further, this issue is of sufficient medical complexity to require expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant contends in this regard that, although Dr. Jansen was unable to determine the etiology of his respiratory problems, she nevertheless opined that claimant's condition was related to occupational chemicals. Certainly, Dr. Jansen's reports suggest a suspicion that claimant's chemical exposures play a role in claimant's respiratory condition. We conclude, however, that Dr. Jansen's reports fall well short of establishing work exposure as the major cause of a worsening of claimant's respiratory condition.

Dr. Jansen reported on August 3, 1987, that claimant's reported history was not completely typical for isocyanate-induced asthma. Instead, she reported that "[o]ther agents (occupational asthma and nonoccupational factors) could be responsible" for claimant's respiratory symptoms. Dr. Jansen also recommended that claimant discontinue both smoking and drinking. Nowhere does Dr. Jansen compare the proportional contributions of claimant's work exposures and his off-work exposures. Nor does Dr. Jansen offer an opinion as to whether claimant's work exposure has resulted in a worsening of his underlying respiratory condition. In sum, the medical evidence fails to establish the compensability of the claim.

ORDER

The Referee's order dated March 1, 1988 is affirmed. The Board approves a client-paid fee, payable from the insurer to its counsel, not to exceed $627.50.

JULIE A. WILKER, Claimant — WCB 87-05438
J. Michael Casey, Claimant's Attorney — November 6, 1989
Barbara Brainard (SAIF), Defense Attorney — Order on Review
Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Monfils' order that upheld the SAIF Corporation's partial denial of claimant's temporomandibular joint ("TMJ") condition. All briefs submitted by the parties have been considered on review. The sole issue on review is compensability. We reverse.

FINDINGS OF FACT

Claimant, 28 years old as of the date of hearing, was injured on June 22, 1986, while working as a string machine operator. This machine makes the inner sheets for plywood. Her work required her to be on a platform 3-1/2 feet from the ground with no railing. At the time of the accident, she slipped or tripped on some pieces of wood on the platform. In an attempt to catch her fall, she flung herself against a pole, thereby hyperextending her back. She struck the pole in the mid-back area and had immediate pain in that area, and below the shoulderblades.

She was able to continue working on the date of the accident. However, she went to the hospital emergency room on June 24, 1986 complaining of mid back and lumbar pain.

Claimant was off work three days after her visit to the emergency room and then returned to work. Claimant's first treatment was with Dr. Damond, chiropractor, nine days after her accident. She treated with Dr. Damond on nine occasions in July, twice in August and five times in September. Her complaints to Dr. Damond extended from her shoulders to her low back. Dr. Damond diagnosed a thoraco-lumbar paraspinal strain.

On July 18, 1986, SAIF accepted a "back strain" by indication to that effect on claimant's 801 claim form.

Claimant moved to the State of Washington on October 1, 1986. She began treating with Dr. King, chiropractor, on October 27, 1986. In addition to low and mid back complaints, claimant reported a two-week history of cervical pain with some paresthesia of the left arm. Claimant had reported a feeling of left arm numbness to Dr. Damond on July 1, 1986. Dr. King diagnosed, among other things, a cervical sprain/strain accompanied by brachial neuritis. Chiropractic manipulation and physical therapy in the form of swim exercise was prescribed.

In November 1986, Dr. King referred claimant for physical therapy. Her physical therapist reported on January 19, 1987, that, in addition to back complaints, claimant reported "some problems with her right TMJ joint popping for which she has been seeing a dentist for correction with bracing possibly to recur in the near future." Claimant had previously been fitted for braces in August 1984. The braces were removed in August 1985. She was wearing a retainer, not braces, at the time of the accident. Claimant had not had prior TMJ problems.

On January 30, 1987, SAIF wrote Dr. Damond to inquire whether claimant had ever mentioned a TMJ problem to him. Dr. Damond responded that he could not recall claimant mentioning TMJ problems to him.

Claimant began treating with Dr. Cooley, dental surgeon, on February 2, 1987, on referral from Dr. King. Dr. Cooley performed a complete exam on February 12, 1987. He diagnosed a TMJ dysfunction, acute inflammation of the joint resulting in chronic pain. He provided a jaw splint to claimant.

On February 6, 1987, SAIF issued a partial denial of claimant's TMJ condition.

Claimant was examined by Dr. Clancey, orthopedic surgeon, on February 9, 1987.

On April 10, 1987, Dr. O'Brien, dentist, rendered a medical opinion regarding the relationship between claimant's injury and her TMJ problems. Dr. O'Brien's report was based upon his review of the medical record and did not include an examination of claimant.

Claimant returned to Oregon in May 1987. She treated with Dr. Lamm, chiropractor, at that time. Approximately one month later, she transferred her care to Dr. Ott, chiropractor.

An oral surgery evaluation was made by Dr. Bouneff, dentist, on June 23, 1987, at the request of SAIF. Dr. Bouneff noted palpable crepitus in the right and left temporomandibular joints with opening of claimant's mouth. Dr. Bouneff also noted a

distinct clicking bilaterally when claimant was asked to go into a protrusive motion. Dr. Bouneff further noted an extremely deep overbite. Dr. Bouneff recommended continued use of splint therapy.

On February 4, 1988, claimant was examined by Dr. Smith, dental surgeon.

FINDINGS OF ULTIMATE FACT

Claimant suffers from temporomandibular joint dysfunction. Her TMJ problems are materially related to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant does have a TMJ condition. We agree. The Referee concluded, however, that claimant failed to establish a causal relationship between that condition and her compensable injury. We do not agree with that conclusion. Our review of the medical record and claimant's testimony persuade us that claimant's TMJ condition is materially related to her June 1986 injury.

The Referee essentially found claimant to be not credible based upon inconsistencies he perceived in the record and her testimony. We generally defer to a Referee's finding regarding credibility when it is based upon the witness' demeanor at hearing. However, when credibility of a witness is based upon the substance of the witness' testimony and the documentary record, as is the case here, then the rationale for deferring to the Referee is not applicable. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

The Referee questions claimant's testimony in part because claimant did not mention a TMJ problem or cervical pain to Dr. Damond despite treating with him numerous times during July through September 1986. The Referee notes that claimant complained of neck and facial symptoms to the Western Medical Consultants in June 1987. He also notes that Dr. Smith reported a history of facial pain dating to July 1986. However, claimant testified that she did not begin to experience jaw symptoms until November 1986. In addition, although she had some neck pain shortly after the accident, the pain only gradually worsened and did not become a significant problem until October or November 1986. We conclude that the fact claimant did not mention facial or neck pain to Dr. Damond does not render her testimony suspect.

The Referee next concluded that the medical evidence fails to establish the necessary link between claimant's injury and her TMJ dysfunction. Therefore, we turn to an examination of the medical evidence.

Although the record contains reports from a number of physicians, several of these physicians express no opinion regarding the causal relationship between claimant's injury and her TMJ condition. Included in this group are Drs. Clancey, Lamm and Ott.

Of the remaining medical opinions, we afford several of them almost no persuasive value. Dr. Damond, for example, opined that there was no causal relationship between claimant's injury and her TMJ condition. While Dr. Damond was at one time

claimant's treating physician, he has not examined claimant since the onset of her TMJ symptoms. In addition, there is no indication that Dr. Damond, a chiropractor, has any notable expertise in evaluating the causes of TMJ dysfunction. Accordingly, we assign no persuasive value to his opinion.

Similarly, Dr. King is a chiropractor with no demonstrated expertise in TMJ dysfunctions. Dr. King implicitly acknowledged his lack of expertise in this area by his referral of claimant to Dr. Cooley. Moreover, Dr. King opined that claimant's TMJ condition was slowing claimant's recovery from her back injury. He expressed no opinion on the relevant question here; whether that injury was a material cause of her TMJ condition.

We also conclude that Dr. Smith's opinion is not helpful. Although an expert on TMJ disorders, Dr. Smith opined that:

> "if [claimant] received a blow to her mandible during an industrial accident, the TMJ disorder and associated facial pain were caused by the industrial accident of June, 1986."

However, claimant does not contend that she received a blow to her mandible at the time of her accident. Instead, the blow was to her mid and low back. Consequently, Dr. Smith's opinion is of no value.

The Referee gave little weight to Dr. O'Brien's opinion. We agree. Dr. O'Brien apparently did not examine claimant. In addition, his opinion is cursory and confusing. He begins his opinion by apparently questioning whether claimant suffers for TMJ syndrome. He concludes his opinion by stating:

> "This is not to imply that [claimant] does not have a TMJ disorder but that no differential diagnosis or supporting evidence is found in [claimant's] file."

The only matter of substance we draw from Dr. O'Brien's report is his opinion that a trauma-related TMJ disorder usually manifests itself as "an immediate and very painful condition."

This opinion conflicts with that of Dr. Cooley. Dr. King referred claimant to Dr. Cooley expressly for the purpose of investigating her TMJ problems. Dr. Cooley did a complete examination of claimant on February 12, 1987. Dr. Cooley reported that it is quite common for TMJ symptoms to develop a number of months following an injury. Moreover, Dr. Cooley reported that the fact claimant had "quite a severe malocclusion of her teeth" rendered her particularly susceptible to TMJ problems. Dr. Cooley was claimant's treating physician for purposes of her TMJ condition. Dr. Cooley's opinion is better informed and better reasoned than Dr. O'Brien's. Consequently, we find Dr. Cooley's opinion more persuasive. Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF, 77 Or App 259 (1986).

Moreover, we find support for Dr. Cooley's analysis in the opinion of Dr. Bouneff. Like Dr. Cooley, Dr. Bouneff felt that claimant was predisposed to TMJ problems. Dr. Bouneff reported in this regard that claimant's extremely deep overbite

was a big contributing factor to the TMJ symptoms. In addition, he opined that claimant's back pain and cervical pain "certainly" aggravated her TMJ condition.

Thus, the only medical opinions with any appreciable persuasive authority are those of Dr. Cooley and Dr. Bouneff. Dr. Cooley reported that claimant's compensable injury caused the onset of her TMJ dysfunction. Dr. Bouneff opined that claimant's compensable injury aggravated the symptoms of a preexisting TMJ condition. The evidence does not support the existence of a preexisting TMJ condition. However, even if claimant experienced preexisting TMJ problems, treatment of claimant's TMJ condition is compensable. See Grace v. SAIF, 76 Or App 511, 517 (1985) (where work injury causes worsening of symptoms of preexisting condition, treatment of symptoms is compensable).

ORDER

The Referee's order dated March 23, 1988 is reversed. The SAIF Corporation's partial denial of claimant's temporomandibular joint disorder is set aside. The claim is remanded to SAIF for acceptance and processing in accordance with law. For his services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $2,250, to be paid by the SAIF Corporation.

BRENDA S. BEWLEY, Claimant	WCB 87-10140
Ackerman, et al., Claimant's Attorneys	November 7, 1989
Employers Defense Counsel, Defense Attorney	Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Miller's order that set aside its denial of claimant's occupational disease claim for right arm/wrist and upper back conditions. Claimant cross-requests review of that portion of the order that declined to assess a penalty or attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are compensability and the assessment of a penalty and/or attorney fee.

FINDINGS OF FACT

Claimant, 21 at hearing, suffered a prior out-of-state injury to her right shoulder in 1985. The record does not establish whether this prior injury was an industrial or nonindustrial injury. Conservative medical treatment was required.

In January, 1987, claimant began working for the insured, a linen company. The insured is partially owned and operated by claimant's sister-in-law, Patricia Boone. Boone was claimant's supervisor. Claimant and Boone did not get along; their relationship was strained.

Claimant's work required the repetitive use of her arms and hands. On May 13, 1987, she sought treatment from Dr. Meharry, M.D., for alleged right wrist pain. Meharry diagnosed right wrist tendinitis and placed claimant on light duty work. Later that day, claimant had a conversation with Shirley Bainbridge, a co-worker. In the course of discussing "getting someone," claimant specifically mentioned Boone.

On May 18, 1987, claimant filed an industrial accident

claim for tendinitis in her right wrist. Meharry eventually referred her to Dr. Peterson, an orthopedic specialist. Peterson diagnosed right shoulder myofascitis, but found no signs of right wrist tendinitis.

CONCLUSIONS OF LAW

Despite finding that Bainbridge's testimony "cast doubt on claimant's story[,]" the Referee concluded that claimant had proven compensability. We disagree.

At the outset, we must determine whether claimant's claim is one for injury or occupational disease. What sets occupational diseases apart from injuries, is that they are neither unexpected given the type of work performed nor sudden in onset. Valtinson v. SAIF, 56 Or App 184 (1982). Here, claimant's right arm/wrist and upper back conditions arose gradually, rather than suddenly. Moreover, her repetitive work activities involving the picking up, tugging, and shaking of linens, were of a type that cannot be said to unexpectedly result in an occupational disease. Accordingly, we conclude that if she is to prove compensability, it must be as an occupational disease.

To prove an occupational disease, claimant must prove that her work activities, when compared to nonwork activities, were the major contributing cause of her conditions. Dethlefs v. Hyster, 295 Or 298 (1983). If her conditions preexisted her employment, she must additionally prove a worsening of the preexisting condition. Weller v. Union Carbide, 288 Or 27 (1979).

Throughout this case, the parties have argued that credibility is a central issue. The Referee appears to have found that claimant was credible, but not reliable. That is, despite finding that claimant was a "generally credible" witness, the Referee also found that her testimony was "colored" and that she was not "objective." Unlike assessing a witness' demeanor, we are in as good of a position as the Referee to assess the substance of a witnesses testimony. Davies v. Hanel Lumber Co., 67 Or App 35 (1984).

Here, claimant initially testified that she had no prior problems to her right hand, arm or right upper back. (Tr. 4). Later, under cross-examination, she was asked if she had had any prior injuries to her right arm, shoulder or neck. (Tr. 120). She replied: "Yes. I dislocated my shoulder in -- on the summer of '85." Id. Such an inconsistency in claimant's testimony indicates that she was something less than a reliable historian. Additional evidence supports a finding of unreliability. Meharry testified, by way of deposition, that claimant never informed him of any prior injuries to her right shoulder area. Likewise, there is nothing in Peterson's chart notes or testimony to indicate that he was aware of claimant's prior 1985 injury. (Ex. 13-6 & 7). Under such circumstances, we conclude that claimant is not credible.

Turning to the medical evidence, Meharry and Peterson do not agree on claimant's diagnosis or her medical conditions. Meharry found no signs of a right shoulder condition, (Ex. 13-11), and diagnosed right wrist tendinitis because "it was the only thing I [Meharry] could come close to as being a diagnosis * * *." (Ex. 13-14). Peterson, in near complete disagreement

with Meharry, found no signs of right wrist tendinitis (Tr. 56) and diagnosed claimant's condition as a scapular condition of the right shoulder. Id. Moreover, Peterson rendered his opinion before claimant testified that she had previously injured and treated for a 1985 right shoulder condition. (Tr. 60 & 61). This is particularly noteworthy because Peterson's opinion is based on the assumption that claimant's right shoulder symptoms began shortly after she began working for the insured. That is not the case, however. In fact, as we found above, claimant's right shoulder symptoms began in 1985, before her employment.

It is well settled that medical opinions based on an inaccurate history are not persuasive. Miller v. Granite Construction Company, 28 Or App 473 (1977). Here, both Meharry and Peterson based their opinions on an inaccurate history. Moreover, when medical opinions are based primarily on the chronological sequence of the worker's onset of symptoms, see Bradshaw v. SAIF, 69 Or App 587, 589 (1984), as here, an inaccurate understanding of that sequence by the medical experts significantly detracts from the persuasiveness of their opinions.

Accordingly, on this record, we conclude that claimant has not proven that her work activities were the major contributing cause of either the onset or worsening of her right arm/wrist or upper back conditions.

Inasmuch as we have found above that claimant has not proven the compensability of her claim, we find that the insurer acted reasonably in denying compensability. We, therefore, find no basis to assess either a penalty or attorney fee.

ORDER

The Referee's order, dated May 27, 1988, is reversed. The insurer's denial is reinstated and upheld. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $752.

THELMA A. DALY, Claimant — WCB 86-12297
Vick & Gutzler, Claimant's Attorneys — November 7, 1989
Jolles, Sokol, et al., Attorneys — Order on Review
Larry Dawson, Defense Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Mulder's order that upheld the insurer's denial of her myocardial infarction.

The Board reverses the order of the Referee.

ISSUE

Whether claimant sustained a compensable myocardial infarction.

FINDINGS OF FACT

Claimant, 52 at the hearing, has been unemployed for most of her adult life. On approximately June 10, 1986, she began working for the insured, a cannery, as a berry sorter. Her job required her to discard unacceptable berries from a conveyor belt. She stood while performing her work.

Normally, claimant worked eight hours a day with a 15 minute break in the morning. She usually took only 15 to 30 minutes for lunch. On June 21, 1986, she began to experience chest pain prior to her morning break. Shortly after her break, her chest pain worsened. In addition, her arms began to ache and she could no longer lift them. She notified her supervisor of her condition and was advised to discontinue working for the remainder of the day.

A member of claimant's family picked her up at work and drove her to a hospital. Dr. Kuehnel, claimant's treating physician, examined her. She suffered an "acute inferior wall infarct[ion]." Kuehnel admitted her to the Coronary Care Unit, where she was examined by Dr. Mundall, a cardiologist.

In September, 1986, claimant was examined by Dr. Rogers, a cardiologist.

ULTIMATE FINDINGS OF FACT

Claimant suffered from hypertension and asymptomatic atherosclerosis prior to the infarction.

Following the infarction, she continued to suffer from angina.

Claimant's work activity was a material contributing cause of her myocardial infarction.

CONCLUSIONS OF LAW

To establish a compensable heart condition, a worker must prove that her work activity was both the legal and the medical cause of the condition. Somers v. SAIF, 77 Or App 259 (1986). Legal causation, in cases of physical exertion, can be established by a worker's usual exertion in her employment. Coday v. Willamette Tug and Barge, 250 Or 39 (1968).

The Referee in this case found that claimant had not proven medical causation. We disagree.

Here, Drs. Kuehnel and Mundall opined that claimant's work activities on June 21, 1986, materially contributed to her myocardial infarction. Dr. Rogers, on the other hand, opined otherwise. When the medical evidence is divided, as here, we must weigh the evidence and choose the correct medical hypothesis. McClendon v. Nabisco Brands, 77 Or App 412 (1986). We generally assign greater weight to the opinion of a worker's treating physician, in the absence of persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

In October, 1987, Dr. Kuehnel reported:

> "The reason why the myocardial infarction occurred on the date that it did was likely due to events that occurred on that day. The infarction occurred during heavy physical manual labor. It is likely that the effort of the labor caused a deficiency in blood supply to the portion of the

heart's downstream from the cholesterol blockage. It is also likely the physical exertion increased the ability or the tendency of the blood to clot. The combination of these factors is what led to the myocardial infarction."

The Referee found Dr. Kuehnel's opinion unpersuasive because it allegedly was based on an inaccurate understanding of claimant's past and present work history. See Miller v. Granite Construction, 28 Or App 473 (1977). We do not agree.

In a report of December, 1987, Dr. Kuehnel clarified his understanding of claimant's work activities, stating:

> "With regard to the question of heavy physical manual labor at the time of the myocardial infarction, it is my recollection that the [claimant] was involved in work on a conveyor belt sorting farm produce. Specifically, I believe she was standing at the conveyor belt and packing fruit under a great deal of time pressure with regard to this job and a significant amount of repetitive movement and bending. The job may not have involved lifting heavy weights, however. With regard to a previous job, it is my impression that the patient had changed from a job which was slightly more sedentary to the one at the fruit packing conveyor belt job, but I cannot remember the details of her previous job."

We find little inaccuracy in Dr. Kuehnel's opinion. First, it is undisputed that claimant worked as a laborer and that she was required to stand while performing her job. Second, it is undisputed that she sorted berries from a continuous running conveyor belt, which required repetitive movements. Last, it is undisputed that prior to her present job as a sorter, she had remained essentially unemployed performing routine "housewife" chores. Her only other employment was as a counter and sorter of dental equipment for a few months in 1981. However, inasmuch as that job did not involve a conveyor belt, she was not under the same type of constant physical demands that were present in her job at the cannery.

Buttressing Kuehnel's opinion is that of Dr. Mundall, who in August, 1986, reported:

> "[Claimant] had recently switched jobs, and was working in a fruit packing plant in Troutdale. The work was different from what she had been used to, and it involved a moderate amount of physical exertion as she stands over the conveyor belt and packs fruit. There is also a great deal of time pressure with the job. [Claimant] does have a history of hypertension, quite severe, a long history of cigarette smoking, and evidence of atherosclerosis in her legs with a prior history of

claudication. * * * Although her work was not the cause of the atherosclerosis[,] the conditions listed above are certainly enough to have precipitated the myocardial infarction to occur at that time."

Similar to Dr. Kuehnel's opinion, we find little inaccuracy in Dr. Mundall's opinion. First, claimant's work at the cannery was, in fact, different than what she had been accustomed to (i.e., domestic chores). Second, even the insured's supervisor conceded that claimant's work involved "moderate" physical labor. Last, given the conveyor belt nature of claimant's work, she was indeed under time pressure.

We turn to Dr. Rogers, who in September, 1986, opined:

"The evidence is clear that [claimant] has single-vessel severe coronary stenotic disease, probably involving both arteriosclerosis and possibly vasospasm, as much of her recurrent angina has occurred at rest. This disease has been probably contributed to by the background of cigarette smoking, hypertension, and positive family history, but apparently without hypercholesterolemia. Psychologically she appears to be rather average, and I would not have expected her to have been particularly emotionally stressed by sorting strawberries. In fact, I think this work was only coincidental to her heart attack and not in any way materially contributing to the onset."

We are not persuaded by Dr. Rogers' opinion. First, unlike either Dr. Kuehnel or Dr. Mundall, Rogers examined claimant on only one occasion. Weiland v. SAIF, supra, 64 Or App at 814. Second, although Rogers dismissed emotional stress as a causative agent, he did little to dispel physical exertion as a contributing factor in causing claimant's myocardial infarction. In fact, Rogers noted:

"[Claimant] seemed well except for controlled hypertension and cigarette smoking until June 21, 1986, at about 1:45 p.m., when after working an hour and a half sorting and stemming strawberries on a conveyor belt at a fairly rapid speed, she developed a new low sternal area tight burning feeling that soon caused her to stop."

Last, Rogers appeared to opine that claimant's myocardial infarction was entirely due to her preexisting cardiovascular disease and family history. See Senters v. SAIF, 91 Or App 704, 708 (1988). However, given Dr. Kuehnel's long term treatment of claimant, we find that he, rather than Rogers, was in the best position to assess the relative causal contribution of claimant's preexisting cardiovascular disease and family history.

Kuehnel did so. In his letter of October, 1987, he stated that claimant's myocardial infarction "was likely due to

events that occurred that day [i.e., June 21, 1986]." Accordingly, we find that claimant's work activities on June 21, 1986, materially contributed to the cause of her myocardial infarction.

ORDER

The Referee's order, dated February 8, 1988, is reversed. The insurer's denial is set aside and it is directed to process the claim according to law. Claimant's attorney is awarded a reasonable assessed of $1,300 for his services at the hearing and $900 for his services on Board review, to be paid by the insurer. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,981.

DAVID G. FERREIRA, Claimant	WCB 87-02440
Malagon, et al., Claimant's Attorneys	November 7, 1989
Garrett, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant, pro se, requests review of Referee Michael Johnson's order which set aside the insurer's "de facto" denial of certain chiropractic billings. Specifically, claimant contends that the Referee erred in finding that claimant was entitled to three chiropractic treatments per month. On review, the issue is reasonableness and necessity of chiropractic treatment.

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

At hearing, the issue was the reasonableness and necessity of the unpaid chiropractic billings. Frequency of future chiropractic treatments was not at issue. Therefore, the Referee's statements concerning such future treatment were gratuitous. Accordingly, we disavow that portion of the Referee's order that purported to limit claimant's future chiropractic treatments to three per month.

ORDER

The Referee's order, dated October 16, 1987, is affirmed.

HELEN R. GULLEY, Claimant	WCB 87-12852
Malagon, et al., Claimant's Attorneys	November 7, 1989
SAIF Corp Legal, Defense Attorney	Order on Review

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Seymour's order that: (1) declined to grant permanent total disability; and (2) increased her unscheduled permanent disability award for a neck and back injury from 35 percent (112 degrees), as awarded by Determination Order, to 75 percent (240 degrees). On review, claimant contends that she is entitled to an award of permanent total disability. We modify.

ISSUES

1. Permanent total disability.
   (a) Did the compensable injury materially contribute

to the onset of claimant's mental stress, resulting in increased disability and requiring additional medical services?

(b) Is claimant permanently incapacitated from regularly performing work at a gainful and suitable occupation?

2. Alternatively, extent of unscheduled permanent partial disability for a neck and back injury. How much permanent loss of earning capacity has claimant suffered due to her compensable injury?

FINDINGS OF FACT

Claimant, an elementary school teacher, compensably strained her neck and low back on May 13, 1983 when she tripped and fell face forward on the school playground. She treated conservatively with Dr. Samuel, a chiropractor, and continued to work through the rest of the school year. During the following summer, she worked at her upholstery business at a reduced pace. She returned to her teaching job in the Fall of 1983 with continuing neck and back symptoms.

When conservative treatment failed to relieve her symptoms, claimant began treating with Dr. Campagna, a neurosurgeon, in October of 1983. Campagna reported constant low back pain with some left leg component, as well as neck and shoulder discomfort. Further conservative treatment failed to provide relief. In December of 1983 claimant was no longer able to work due to continuing symptoms, and has not worked since.

A myelogram and CT scan in February of 1984 revealed cervical spondylosis with cord compression at C5-6 and C6-7, and a herniated disc at L5-S1. In March and April of 1984, claimant underwent a lumbar laminectomy and a cervical laminectomy at C5, C6 and C7, all of which resulted from the compensable injury.

On June 30, 1986, claimant saw Dr. Kirkpatrick for a psychiatric evaluation. Kirkpatrick reported insomnia, agitation and mild depression, and commenced treatment with group therapy.

Claimant became medically stationary, both physically and psychologically, by July 23, 1987. The claim was closed by Determination Order on August 12, 1987 with 35 percent unscheduled permanent disability.

At the time of hearing, claimant continued to have frequent low back pain, shoulder pain and numbness in the right arm. She has limitations on standing, walking, sitting, bending, stooping, twisting, lifting, and looking up or down. She takes pain medication once or twice weekly and has to lie down on a recliner from two to four times daily. She treats with Dr. Samuel twice monthly. Claimant's permanent physical impairment due to the compensable injury is mildly moderate.

In addition to her physical limitations, claimant has difficulties coping with stress. Whereas she had no problems coping with stress prior to the compensable injury, she now experiences stress difficulties on the average of two to three days weekly. These difficulties impair her ability to concentrate and to make decisions regarding "little things," such as what clothes to wear. Moreover, she has difficulty coping with stress resulting from her apparent inability to satisfy her husband's demands for attention. Claimant's permanent psychological impairment due to the compensable injury is minimal to mild.

Claimant is 60 years of age and has been married to her husband for more than 39 years. She has four-year college degrees in English and elementary education, and her work experience is limited to elementary school teaching and upholstery. She cannot return to those occupations on a full-time basis due to her physical and psychological limitations. Currently, claimant spends much of her day helping out at her husband's myrtle wood shop and her daughter's drapery shop. She owns an upholstery shop but works only in a supervisory capacity. She also cares for an aging relative who has lived in her home for the previous ten years.

FINDINGS OF ULTIMATE FACT

The compensable back injury materially contributed to the onset of claimant's mental stress problems, resulting in increased disability and requiring additional medical services.

We do not find that claimant is permanently incapacitated from regularly performing any work at a gainful and suitable occupation.

Claimant has suffered 85 percent permanent loss of earning capacity due to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant is not permanently and totally disabled and, instead, increased her award of unscheduled permanent disability. We agree with the Referee's conclusion but modify his unscheduled permanent partial disability award.

Permanent Total Disability

1. Compensability of mental stress.

The Referee declined to consider claimant's stress problems, finding that those problems were not related to her compensable injury.

Claimant's disabling symptoms are both physical and psychological. We first must determine whether claimant's psychological problems can be considered in evaluating the extent of her permanent disability. Claimant contends that those problems are a compensable consequence of her industrial injury. To establish compensability under that theory, claimant must prove that her industrial injury materially contributed to the onset or worsening of her psychological condition. Grace v. SAIF, 76 Or App 511, 515 (1985); Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985). "Material contributing cause" means a substantial cause, but not necessarily the sole, or even the most significant, cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Lobato v. SAIF, 75 Or App 488, 492 (1985).

Both the medical evidence and claimant's testimony clearly establish that she is having difficulty coping with stress, which impairs her decision-making process. The Referee related those "stress problems" to matters unrelated to the compensable injury but failed to explain that finding. We

disagree. Although much of claimant's stress originates from various non-industrial sources, particularly marital discord, we find that her ability to cope with stress has been substantially impaired by the compensable injury.

Dr. Kirkpatrick, the treating psychiatrist since June, 1986, wrote that claimant's "coping capabilities" had diminished since the industrial accident. He explained that "ongoing marital dynamics" have been strained by her emotional and physical needs, thereby accelerating a dependency conflict between claimant and her husband whom she used to dote on, and causing interpersonal and intrapsychic conflict. He added that claimant has "persisting and significant depressive conflict" concerning her "great quandary [sic] about how she can take care of her own personal, emotional and physical rehabilitation needs while responding to her husband's insistence that she look after him as well."

On the other hand, Dr. Hughes, a psychiatrist who examined claimant on SAIF's behalf, opined that her psychological problems were not related to the compensable injury, but rather were ongoing adjustment-type difficulties related to personal problems, specifically those associated with her marriage.

We are most persuaded by Kirkpatrick's conclusions for two reasons. First, as treating physician, his opinion is entitled to greater weight in our determination. Weiland v. SAIF, 64 Or App 810, 814 (1983). Second, his opinion was well-reasoned and consistent with claimant's testimony that she had difficulty coping with stress only after she suffered the compensable injury. We find, therefore, that the compensable injury materially contributed to the onset of claimant's stress problems, resulting in increased disability and requiring additional medical services. We conclude, therefore, that these problems are a compensable consequence of the compensable back injury and can be considered in rating the extent of her disability.

2. Permanent total disability.

To establish her entitlement to permanent total disability (PTD), claimant must prove that she is unable to perform regularly any work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403, 408-09 (1977). Claimant is not totally incapacitated on a physical or medical basis. She is capable of performing sedentary work. Consequently, she can prevail only by proving that she falls within the so-called "odd-lot" doctrine. Under that doctrine, a disabled person who is physically capable of performing work of some kind may still be permanently and totally disabled due to a combination of her physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Claimant is not entitled to a PTD award if she is capable of regularly performing at least part-time work. Georgia-Pacific Corp. v. Perry, 92 Or App 56, 58 (1988); Hill v. SAIF, 25 Or App 697, 701 (1976).

Dr. Samuel, claimant's treating chiropractor, opined that, as a result of the industrial injury, claimant would need flexible work hours with no bending at the waist, no stooping and no twisting. He added that claimant needs to lie down or rest in

a recliner from one to two hours daily. While opining that claimant's employability was limited due to medical and nonmedical factors, he stopped short of declaring her unemployable. He felt that elementary school teaching is beyond claimant's physical restrictions against bending and stooping and that substitute teaching "would entail more daily hours than [claimant] could achieve." However, he added that she could perhaps tutor one to two hours daily. The Orthopaedic Consultants examined claimant at SAIF's request and opined that claimant could return to her original teaching job with limitations or to some other type of light to medium work.

Similarly, the psychological evidence alone does not establish that claimant is unemployable. Kirkpatrick stated that claimant's psychological condition does not preclude her from at least modified work.

Only Mr. McNaught, a vocational consultant testifying on claimant's behalf, concluded that claimant is unemployable. He explained that claimant's physical condition and stress difficulties render her unable to compete in the labor market. Specifically, he noted that claimant is restricted to sedentary work that would allow her to sit and stand as necessary and to lie down from two to four times each day. He added that claimant has difficulty concentrating and making decisions regarding daily living activities. Additionally, claimant testified that her physical condition and/or stress difficulties would prevent her from returning to work in either elementary school teaching or upholstery.

Although claimant clearly has restrictions that limit her employability, those restrictions do not altogether preclude her from regularly performing any work at a gainful and suitable occupation. Claimant testified that she could avoid bending while performing her teaching duties but that she could not do so "all day long." (Tr 23). She added that prolonged sitting and the long hours required to check her students' work also are problems. (Tr 21-22, 49). She further testified to the lack of available time for lying down. (Tr 23). However, claimant's testimony apparently addresses problems associated with and peculiar to full-time teaching. We are persuaded that the restrictions outlined by Samuel and McNaught can be accommodated, if not avoided, in a part-time teaching position. Indeed, in late 1986 Samuel released claimant for four-hour work days in teaching, though claimant was not rehired for reasons unrelated to her injury. She has not looked for a part-time teaching position since that time.

Furthermore, there is no evidence that claimant's stress problems preclude part-time teaching altogether. Finally, we note that claimant's college education and more then 20 years of prior experience in teaching are additional aids in obtaining and regularly performing part-time work. Although claimant's advanced age reduces her employability, we are not persuaded that it renders her unemployable. Because we find that claimant can regularly perform at least part-time work, she is not entitled to PTD benefits. See id.

Extent of Unscheduled Permanent Disability

The criterion for rating unscheduled permanent partial

disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Consistent with our finding that claimant's stress problems are materially related to the compensable injury, we now consider those problems, along with claimant's physical limitations, in our evaluation of claimant's unscheduled permanent partial disability. Dr. Kirkpatrick, claimant's treating psychiatrist, rated her psychiatric impairment as 10 percent, which presumably represents minimal to mild impairment. As treating physician, his opinion is given greater probative weight. See Weiland v. SAIF, supra. Claimant's physical restrictions alone represent mildly moderate impairment. Claimant's earning capacity is further impacted by her advanced age and limited work experience. After reviewing the medical and relevant nonmedical factors, we conclude that claimant suffered an 85 percent loss of earning capacity due to the compensable injury.

ORDER

The Referee's order dated January 26, 1988, is modified in part and affirmed in part. In addition to the Determination Order award of 35 percent (112 degrees) unscheduled permanent disability, and the Referee's additional award of 40 percent (128 degrees) unscheduled permanent disability, claimant is awarded an additional 10 percent (32 degrees) unscheduled permanent disability, giving her a total unscheduled disability award of 85 percent (272 degrees). The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation granted by this order. However, the total of fees approved by the Referee and Board shall not exceed $3,800.

SANDRA J. LAMB, Claimant
Phil H. Ringle, Jr., Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 88-00359
November 7, 1989
Order on Reconsideration

Claimant's counsel seeks an assessed attorney fee for services rendered on review, which culminated in our October 27, 1989 Order on Review.

The insurer requested review in this case and filed a brief. Rather than file a responsive brief, claimant rested on the record. Claimant's attorney is, therefore, not entitled to an assessed fee on Board review. Shirley M. Brown, 40 Van Natta 879, 882-83 (1988). Although claimant performed services responding to the insurer's motion for reconsideration of the Referee's order, those services were performed before jurisdiction vested with the Board, and, therefore, were not services on Board review. On this record, there are no "documented" services that have been performed on Board review. Brown, 40 Van Natta at 883.

Accordingly, claimant's request for reconsideration is

granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

MARIA D. OREJEL, Claimant
Michael B. Dye, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 88-19157
November 7, 1989
Order Denying Request

Reviewed by Board Members Gerner and Crider.

The insurer's counsel seeks authorization of a client-paid fee for services rendered before the Board which culminated in our September 14, 1989 Order of Dismissal. The request is denied.

FINDINGS

On July 6, 1989, the insurer requested Board review of the Referee's June 14, 1989 order. On August 25, 1989, the insurer notified the Board that it was withdrawing its request for review and was asking for a dismissal order.

On September 14, 1989, the Board issued an Order of Dismissal. The order did not address the issue of a client-paid fee. The September 14, 1989 order has not been appealed, abated, stayed or republished.

On October 24, 1989, the insurer's counsel sought authorization of a client-paid fee. Included with the request was an executed attorney retainer agreement and a statement of service.

CONCLUSIONS

Statements of services for Board review of a Referee's order shall be submitted to the Board within 15 days of the filing, or expiration of the time for filing, of the last brief. OAR 438-15-028(1)(c). Our rules concerning the filing of statements of services do not expressly discuss situations where the services are provided prior to the filing of briefs on Board review. However, we have previously held that filing requirements for such matters should be in keeping with other Board proceedings. See John Scrivner, 40 Van Natta 1089, 1090 (1988).

Here, the insurer's counsel's submission has arrived some two months after its motion for dismissal and approximately 40 days after our dismissal order. Under such circumstances, we conclude that the request for authorization of a client-paid fee is untimely.

Statements of services not submitted within the times provided in the Board's rules shall not be considered for approval unless we retain jurisdiction to authorize an attorney fee, and the statement is accompanied by a written explanation setting forth good cause for failure to comply with the Board's rules together with an original and 6 copies of a proposed order authorizing the attorney fee requested.
OAR 438-15-028(2)(a), (b).

Inasmuch as our dismissal order neither addressed the

issue of the insurer's counsel's entitlement to, or the amount of, a client-paid fee, we conclude that we have jurisdiction to consider the request for authorization. See Jane E. Stanley, 40 Van Natta 831 (1988), rev'd on other grounds Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (August 30, 1989). Yet, the request for authorization has not been accompanied by either a written explanation setting forth good cause for the failure to comply with the Board rules or an original and 6 copies of a proposed order. See OAR 438-15-028(2)(b). Lacking such an explanation and proposed order, we currently decline to consider the request for authorization.

Accordingly, the request for authorization is denied.

IT IS SO ORDERED.

JIM STAHLMAN, Claimant
Brian R. Whitehead, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 88-14976
November 7, 1989
Order on Reconsideration

On October 24, 1989, in accordance with the self-insured employer's withdrawal of its request for review, we issued our Order of Dismissal. Claimant has requested a carrier-paid fee for prevailing against the employer's appeal of the Referee's order.

The request is denied. Where a carrier's request for Board reivew is dismissed prior to our review, claimant is not entitled to an attorney fee. Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Matthew W. Johnson, 40 Van Natta 393 (1988); Rodney C. Strauss, 37 Van Natta 1212, 1214 (1985).

Accordingly, our October 24, 1989 order is withdrawn. As supplemented herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

LINDA L. FISCHER, Personal Representative of the Estate of
ALVIN L. DICK, deceased, Claimant
Francesconi & Cash, Attorneys
John Motley (SAIF), Defense Attorney

WCB 85-13494
November 8, 1989
Order on Remand

Reviewed by Board Members Nichols, Brittingham, and Crider.

This case is before the Board on remand from the Court of Appeals. Dick v. Spaur, 93 Or App 448 (1988). The court held that the Referee and the Board had erred in determining that claimant's left shoulder symptoms were not compensable and remanded the case for reconsideration. We process with our reconsideration.

Claimant requests review of Referee Seifert's order that awarded no permanent partial disability for his left shoulder in excess of the 30 percent (96 degrees) awarded by Determination Order. On reconsideration, we affirm the order of the Referee, but for the reasons stated in this order.

ISSUE

Extent of disability for claimant's left shoulder, including permanent total disability.

FINDINGS OF FACT

Claimant injured his left shoulder and simultaneously suffered a myocardial infarction on August 17, 1984 while operating a front end loader at work. Both conditions were denied by SAIF. The myocardial infarction was the subject of a disputed claim settlement approved on February 21, 1985. The shoulder condition was ordered accepted by Opinion and Order dated June 28, 1985. The claim for the shoulder condition was closed by Determination Order dated October 28, 1985 with an award of 30 percent (96 degrees) unscheduled permanent partial disability.

Claimant had a number of medical problems before the August 1984 injury. In 1974, he was diagnosed as having high blood pressure. This condition was controlled with medication. In 1975, he began to develop cramping in both calves which worsened with time and ultimately was identified as intermittent claudication. At the time of the left shoulder injury in 1984, this condition limited claimant's ability to walk to two blocks. In August 1976, claimant suffered an acute inferior myocardial infarction. Tests revealed significant blockage of the coronary arteries and several other major arteries throughout claimant's body due to atherosclerosis. This condition continued to worsen between August 1976 and August 1984. In 1982, claimant began to experience neck pain. A claim was filed and accepted in 1983 for neck and shoulder complaints. Degenerative cervical arthritis was diagnosed in June 1984.

Claimant began working as a heavy equipment operator for the employer in about June 1984. Before that, he had worked in the same capacity for a variety of employers since the mid 1940's. This kind of work requires use of both upper extremities for the operation of hand controls.

Claimant was examined in June 1984 for complaints relative to his cardiovascular condition, but he continued to work.

After the August 1984 injury, claimant experienced pain and limitation of motion in his left shoulder. Dr. Paluska, an orthopedic surgeon, diagnosed adhesive capsulitis and prescribed a variety of conservative treatment modalities. Claimant's condition improved significantly with these treatments. Paluska declared claimant's shoulder condition medically stationary in August 1985. He offered no specific impairment rating, but did indicate that claimant was capable of lifting up to 20 pounds frequently and up to 50 pounds occasionally. He later indicated that these capacities related to the shoulder condition only and did not take into consideration claimant's vascular or heart problems. A panel of physicians from BBV Medical Services examined claimant in August 1985 and rated his left shoulder impairment at 10 to 15 percent.

Claimant's August 1984 myocardial infarction was treated by cardiac specialists and then was followed by Dr. Davies, a general practitioner. Claimant was assigned to a vocational assistance provider in August 1985. In October 1985, the vocational counselor wrote Dr. Davies for his opinion of claimant's physical abilities. Dr. Davies replied that he considered claimant unemployable due to his severe atherosclerosis. Dr. Paluska expressed a similar opinion in November 1985. Vocational assistance was terminated in January

1986 as impractical in view of claimant's heart and vascular conditions.

In May 1986, Dr. Rush, a cardiologist who took part in the treatment of claimant's August 1984 myocardial infarction, stated that he considered claimant unemployable due to his vascular and heart conditions. In July 1986, Dr. Paluska indicated that claimant was capable of pushing and pulling with both upper extremities. At the hearing, Byron McNaught, a vocational counselor, opined that claimant was capable of working as a heavy equipment operator or in a number of other occupations.

Claimant was 63 years old at the time of the hearing. He is a high school graduate.

FINDINGS OF ULTIMATE FACT

Claimant is incapable of regularly performing work at a gainful and suitable occupation due to his vascular and cardiac conditions irrespective of his left shoulder condition. Considering claimant's left shoulder condition, and his cardiac and vascular conditions as they existed immediately prior to the industrial injury, claimant is capable of working as a heavy equipment operator or in a number of other occupations. The impairment resulting from the industrial injury is in the mild range.

CONCLUSIONS OF LAW

"Permanent total disability" is "the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a). To be entitled to an award of permanent total disability, the permanent total disability must result from the compensable injury. ORS 656.206(2)(a). Permanent total disability which results from the post-injury worsening of a preexisting condition independent of the compensable injury does not entitle the claimant to compensation for permanent total disability. Emmons v. SAIF, 34 Or App 603, 605 (1978). If the compensable condition did not cause permanent worsening of a pre-existing condition, we consider only impairment due to the pre-existing condition as it existed on the date of the injury. Bob G. O'Neal, 37 Van Natta 255 (1985); Aff'd Mem. O'Neal v. Borden, Inc., 77 OR App 194 (1985); Walter R. Searles, 41 Van Natta 627, 629 (1989).

In the present case, claimant had a number of medical problems before the August 1984 industrial injury which significantly limited his ability to regularly perform gainful and suitable work. He had worked as a heavy equipment operator despite these problems for a number of years, however, and continued to do so at the time of the industrial injury. Therefore, he was not permanently and totally disabled before the industrial injury.

After the industrial injury and the noncompensable myocardial infarction which coincided with it, a number of doctors opined that claimant was incapable of regularly performing work at a gainful and suitable occupation. These opinions were based upon

claimant's cardiac and vascular conditions as they existed after the industrial injury independent of the effects of the industrial injury to his shoulder. Dr. Paluska, the doctor who treated the industrial injury to claimant's left shoulder, indicated that claimant was capable of working as a heavy equipment operator after the industrial injury but for his cardiac and vascular conditions. (Ex 58) The only reasonable inference from the above facts is that claimant's cardiac and vascular conditions worsened contemporaneous with, or subsequent to, the industrial injury and that this worsening resulted in claimant's permanent total disability independent of his compensable left shoulder condition. Under these circumstances, claimant's permanent total disability status did not result from the shoulder injury and he is not entitled to a permanent total disability award. Emmons v. SAIF, supra, 34 Or App at 605. We turn, therefore, to an evaluation of claimant's permanent partial disability.

The criterion for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Company, 296 Or 505, 510 (1984).

Considering claimant's mild impairment and the relevant social and vocational factors, we conclude that the extent of claimant's unscheduled permanent partial disability does not exceed the 30 percent unscheduled permanent disability granted by Determination Order and affirmed by the Referee. We conclude, therefore, that the award previously granted should be affirmed.

ORDER

The Referee's order dated August 2, 1986 is affirmed.

Board Member Crider, dissenting.

Claimant is permanently and totally disabled due to a combination of his compensable left shoulder injury and his preexisting severe cardiac and vascular disease. The majority's holding to the contrary is based on unsupportable findings of fact. First, they find that claimant's frozen shoulder does not preclude him from working as a heavy equipment operator. Second, they find that he became totally disabled by his cardiac and vascular conditions alone. Consequently, they conclude that his total disability is independent of his compensable condition. Due to these errors, I dissent.

Claimant was 61 years old when he suffered a compensable left shoulder injury while working as a heavy equipment operator in August, 1984. He had worked in such positions for many years and continued to do so despite increasingly severe cardiac and vascular disease which limited him to walking one or two blocks at a time due to claudication. Prior to the injury, he also suffered periodic angina which he treated with nitroglycerine.

Simultaneously with the compensable injury, claimant suffered a myocardial infarction. The record is clear that claimant fully recovered from the infarction. His cardiac and vascular condition was the same post-infarction as it had been pre-infarction. His physician, as well as the Orthopaedic Consultants, observed that his inability to return to work post-injury was due to his shoulder injury which left him unable to use the shoulder to manipulate the controls of heavy equipment. Only much later, when vocational services were under consideration, did claimant's physicians report that vocational rehabilitation was unrealistic due to claimant's cardiac and vascular condition and, ultimately, that he would be permanently and totally disabled due to the cardiac condition alone.

The majority has seized on these reports that claimant is unable to work due to the cardiac condition alone and found, in effect, that his inescapable shoulder impairment plays no part in his disability. This is error, for claimant was disabled due to the shoulder injury long before his physicians instructed him not to participate in vocational rehabilitation efforts due to his noncompensable condition.

As early as February 6, 1985, the Orthopaedic Consultants reported that claimant was unable to work due to the combination of his cardiac and shoulder conditions. No one suggests that claimant has been able to work since that time. Nonetheless, the majority concludes that claimant could perform work as a heavy equipment operator, but for the cardiac condition which they infer has worsened since the compensable injury. There is evidence that claimant's cardiac condition did progress from 1976 to 1986 in that his use of nitroglycerine has increased during that time. The question, however, is whether the cardiac condition has rendered claimant more disabled from August 1984 until he became permanently and totally disabled. The record indicates that claimant became totally disabled long before any cardiac worsening occurred; for in February 1985 claimant was still taking only occasional nitroglycerine and nonetheless he could not work.

The majority's finding that claimant could operate heavy equipment, the shoulder condition notwithstanding, is equally flawed. Claimant, a longtime operator of such equipment, has credibly testified that his frozen shoulder makes it impossible to operate such equipment. Moreover, Byron McNaught's opinion to the contrary was based on the assumption that Dr. Paluska's physical capacities analysis, prepared on the eve of hearing, was more accurate than his August, 1985 analysis. However, the reverse is true. The range of motion findings in the reports accompanying the analyses suggest that claimant's condition was the same, if not worse, nine days before hearing than it had been before. Consequently, Dr. Paluska's 1985 and 1986 analyses reflected identical restrictions. However, the 1985 analysis was made on a form which distinguished between ability to repetitively operate hand controls with the right and the left arm whereas the 1986 analysis was made on a form which did not distinguish between the right and the left. On the 1985 form, Paluska noted that claimant could perform that function with the right but not the left arm. On the 1986 form, on which McNaught relied, Paluska indicated claimant could operate hand controls. The record as a whole simply does not support the view that claimant's condition improved such that he could perform work at the time of hearing

that he could not perform at an earlier point. Therefore, the majority's finding that claimant could have returned to his regular work but for his noncompensable condition is incorrect.

As a practical matter, claimant was in very poor condition from a cardiovascular point of view for many years but managed, despite major limitations, to work. He then suffered a shoulder injury that prevented him from doing the work he had done for many, many years. That tipped him over the edge. His doctors got into the act, telling him that he should not be working anyway due to his cardiovascular condition. Claimant was totally disabled without reference to any post-injury cardiac worsening. He is, therefore, entitled to the award he seeks.

JAMES L. GUYTON, Claimant
Peter W. McSwain, Claimant's Attorney
Shelley McIntyre (SAIF), Defense Attorney

WCB 89-00257
November 8, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Myers' order that found that he lacked jurisdiction to direct the SAIF Corporation to provide benefits as a processing agent for an alleged noncomplying employer because the Director of the Department of Insurance and Finance had not first referred the claim to SAIF under ORS 656.054. On review, claimant contends that SAIF was required to comply with a prior Referee's order directing it to process the claim on behalf of the alleged noncomplying employer pursuant to ORS 656.054.

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

Subsequent to the Referee's order, we vacated that portion of the prior Referee's order which had directed SAIF to process the claim as a processing agent for an alleged noncomplying employer. See James L. Guyton, 41 Van Natta 1277 (1989). We reasoned that since SAIF was not a party to the previous hearing as a processing agent for a noncomplying employer under ORS 656.054, the prior Referee lacked personal jurisdiction over either the alleged noncomplying employer or SAIF. We further held that the prior Referee was without authority to refer a claim to SAIF for processing under ORS 656.054.

The aforementioned reasoning lends further support for the present Referee's conclusion that, because the prior Referee lacked jurisdiction to refer the claim to SAIF for processing, he was without authority to direct SAIF to comply with the prior Referee's order. Moreover, considering the prior Referee's lack of jurisdiction, we find that SAIF's failure to comply with the order was not unreasonable.

ORDER

The Referee's order dated April 6, 1989 is affirmed.

WANDA S. HAMILTON, Claimant
Samuel A. Hall, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Foss, Whitty, et al., Defense Attorneys

WCB 85-06850 & 86-13809
November 8, 1989
Order on Review

Reviewed by Board Members Brittingham and Nichols.

Liberty Northwest Insurance Corporation requests review of Referee Gruber's order that: (1) set aside its denial of claimant's aggravation claim for a right arm condition; and (2) upheld a denial of claimant's "new occupational disease" claim for the same condition issued by the SAIF Corporation. Liberty also challenges the Referee's refusal to admit evidence not timely submitted prior to hearing. Liberty requests that the Board consider the evidence on review, or remand the case for inclusion of the evidence in the hearing record.

On review, the issues are remand and responsibility.

We deny Liberty's request for remand to consider additional evidence and affirm the Referee's order.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except that we find that Dr. Mann released claimant to return to her regular work in April 1985, rather than August 1985. We make the following additional findings.

Liberty was on the risk when claimant developed her initial right hand and forearm condition in 1983 and 1984. It accepted claimant's occupational disease claim for that condition.

The Determination Order closing claimant's occupational disease claim in January 1985 awarded her 10 percent permanent partial disability of the right forearm (wrist). At the time that claim was closed, claimant was unable to perform any work involving strenuous or repetitive hand movements without a significant increase in symptoms. At various times, she had experienced pain, swelling and numbness in her right hand, wrist, and forearm; pain, numbness and tingling in her right fingers; loss of grip and pinch strength in her right hand; and fatigue in her right forearm. Her objective findings had included a positive Tinel's sign on the right in August 1984 and March 1985. Her condition had been variously diagnosed as carpal tunnel syndrome, tendinitis, probable tenosynovitis, possible ganglion flexor tendon, and arthritis.

Claimant's new employer in August 1985 was insured by SAIF. When claimant began that employment, her right upper extremity symptoms were minimal, and she had not received medical treatment for roughly three months. She demonstrated flexor tenosynovitis in the right palm when she was examined by Dr. Mann in September 1985. Her right forearm and wrist pain did not resolve after she left her employment with SAIF's insured in October 1985. She demonstrated a positive Phalen's sign on the right when Dr. Mann examined her in March 1986. Dr. Lindsey diagnosed her condition as tenosynovitis and carpal tunnel syndrome when he examined her in May 1986.

Claimant filed claims for her current condition with Liberty and SAIF. Both insurers denied responsibility, and claimant requested a hearing in October 1986.

The hearing was scheduled for May 14, 1987, and the parties were so notified on February 6, 1986. On April 9, 1987, counsel for Liberty requested copies of the documents SAIF intended to rely on at hearing, and he received those copies on April 23, 1987. That same day, he contacted Dr. Mann to arrange for a review of SAIF's submissions and an opinion on the responsibility issue. Dr. Mann rendered the requested opinion on May 4, 1987, and Liberty submitted the report the following day. At hearing, Liberty requested inclusion of the opinion in the record and offered to make Dr. Mann available for deposition. The Referee declined to admit the opinion.

FINDINGS OF ULTIMATE FACT

Liberty could have, with due diligence, obtained and submitted Dr. Mann's May 4, 1987 report in a timely fashion.

Claimant's work activity with SAIF's insured did not independently contribute to her right forearm condition.

CONCLUSIONS OF LAW AND OPINION

Remand/Evidence

Liberty argues that the Referee erred in declining to admit Dr. Mann's May 4, 1987 report. It asks the Board to consider the report in its review. In the alternative, it requests that the Board remand the case to the Referee for consideration of the report.

Proceedings on Board review are limited to the record developed by the Referee. ORS 656.295(3) and (5). It would, therefore, not be proper for us to consider Dr. Mann's report in conducting our review.

Furthermore, we conclude that the Referee properly declined to admit Dr. Mann's report. Liberty argues that it had good cause for its late submission of the report. Consequently, it contends that the Referee abused his discretion in not admitting the report. In support of its position, Liberty relies on the Board's decision in Henry L. Mischel, 38 Van Natta 1274 (1986). In that case, the Board reversed the Referee's decision not to admit untimely submitted evidence.

Liberty's reliance on the Mischel decision is misplaced. The party moving for admission in Mischel relied on the so-called "seven-day rule", which was in effect at that time. This rule provided for admission of additional evidence so long as it was submitted within seven days of receipt. However, a temporary administrative rule repealing this special exception became effective for a six-month period, beginning April 15, 1987. As a result, the "seven-day rule" was not in effect when the present case went to hearing.

The Referee's ruling should, instead, be reviewed according to the administrative rules in effect at the time this case went to hearing. Under those rules, insurers were required

to submit evidence at least twenty days prior to hearing, and claimants were required to submit any additional exhibits no later than ten days prior to hearing. Former OAR 438-07-005(3). Evidence not submitted within these deadlines was otherwise admissible at the discretion of the Referee upon a showing of good cause. Former OAR 438-07-005(4).

We conclude that the Referee's refusal to admit Dr. Mann's report was not an abuse of discretion under these rules. We recognize that SAIF probably would not have been prejudiced by admission of the report because Dr. Mann was available for deposition. Nevertheless, the exhibits submitted by SAIF did not include any reports which Liberty Northwest had not had in its own files for some time. Furthermore, as the Referee noted at the time of his ruling, Liberty Northwest was fully aware of the basic theory of SAIF's case prior to receiving SAIF's proposed exhibits. Any need for further clarification from Dr. Mann should have been apparent, irrespective of the particular exhibits SAIF planned to rely on at hearing. Under these circumstances, the Referee did not abuse his discretion in declining to admit Dr. Mann's report.

Finally, we deny Liberty's request for remand for consideration of Dr. Mann's report. The Board may remand a case for the receipt of additional evidence if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, the moving party must clearly show that the evidence was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985). For the reasons discussed above, we are persuaded that Liberty could have, with due diligence, obtained and submitted Dr. Mann's report in a timely manner.

Responsibility

Liberty is responsible for claimant's right arm condition if the later work activity with SAIF's insured did not independently contribute to the condition, but merely resulted in a symptomatic flare-up. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The Referee assigned responsibility to Liberty. We affirm his decision with the following comment.

The Referee premised his decision on a finding that claimant's symptoms had remained essentially the same since their initial onset in 1983. Liberty challenges that finding, noting that claimant's symptoms resolved with rest following Liberty's exposure, but did not do so when she stopped working for SAIF's insured. Liberty also notes that: claimant demonstrated a positive Tinel's sign and flexor tenosynovitis following her work for SAIF's insured; claimant's condition was not "unequivocally" diagnosed as tenosynovitis until May 1986; and claimant's treating physicians recommended that she not return to work as a crab shaker following her symptomatic flare-up in August 1985. Liberty contends this evidence demonstrates that claimant's employment with SAIF's insured independently contributed to her condition.

We are not persuaded by Liberty's argument. Claimant had previously demonstrated a positive Tinel's sign in August 1984 and March 1985, and Dr. Button had diagnosed probable

tenosynovitis when he examined claimant in April 1984. Furthermore, claimant's treating physicians and her vocational counselor expressed reservations regarding her ability to return to work as a crab shaker long before she commenced work with SAIF's insured in August 1985. Consequently, we agree with the Referee's finding that claimant's symptoms had been essentially unchanged since the onset of her condition.

Moreover, assuming that claimant's symptoms had increased, we would still assign responsibility to Liberty. Symptomatic flare-ups were anticipated with claimant's repetitive use of her right hand and forearm. Furthermore, the only medical opinion supporting an independent contribution is a cryptic note from a Dr. Bert, M.D. That opinion is entitled to little weight because it is both conclusory and based on a file review, rather than personal observation. Moe v. Ceiling Systems, 44 Or App 429 (1980); Weilard v. SAIF, 64 Or App 810 (1983). Given this record, an increase in symptoms is not sufficient to demonstrate an independent contribution and shift responsibility to SAIF. See Spurlock v. International Paper, 89 Or App 461 (1988).

Accordingly, we affirm the Referee's assignment of responsibility to Liberty.

ORDER

The Referee's order dated June 26, 1987 is affirmed. The Board approves a client-paid fee for counsel for Liberty Northwest Insurance Corporation, not to exceed $160.

DOROTHY B. HENRY, Claimant — WCB 87-12948
Horton & Koenig, Claimant's Attorneys — November 8, 1989
Employers Defense Counsel, Defense Attorney — Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Gruber's order that: (1) declined to grant permanent total disability; and (2) awarded 40 percent (128 degrees) unscheduled permanent partial disability for claimant's back, in lieu of a Determination Order which awarded 20 percent (64 degrees) unscheduled permanent partial disability. Claimant contends that she is permanently totally disabled, or, in the alternative, that she is entitled to a greater award of permanent partial disability. The issue on review is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

Claimant compensably injured her back on October 4, 1984 while working in a department store. The injury occurred when a stack of boxes fell on her, knocking her to the floor. Claimant was transported to the hospital for emergency treatment. She was hospitalized for approximately two weeks with a diagnosis of acute low back strain.

Claimant began treating with Dr. Litchman, family physician. Although claimant has been seen by other doctors, Dr. Litchman remains her treating physician. He has treated her conservatively.

A May 3, 1985 CT scan disclosed mild L4-5 and L3-4 disc bulging, but no herniation.

In February 1986, claimant returned to light duty work addressing envelopes for the employer. However, she was unable to successfully continue in this light duty position. In March 1986, she was admitted to an injured workers' program at Sacred Heart General Hospital in Eugene, Oregon. Claimant was discharged from this program approximately five weeks later.

Claimant continued to complain of a dull aching low back pain with occasional sharp components with radiation to the right leg. She subsequently underwent an MRI scan on November 13, 1986. The scan results were of poor quality, but disclosed no herniation. Claimant refused to undergo a repeat scan.

On December 30, 1986, Dr. Litchman reported that, in addition to a chronic lumbosacral strain, claimant also suffers from atherosclerotic peripherovascular disease. He recommended enrollment in a pain program followed by vocational counseling.

Claimant was interviewed for admission to the Oregon Pain Center on February 9, 1987. She was found to be exhibiting chronic pain syndrome and depression. She was admitted to the program on February 23, 1987 and discharged March 13, 1987. On discharge, her primary diagnosis was lumbar myofascial syndrome. Her condition was reported as improved upon discharge.

Claimant was referred for vocational counseling on March 4, 1987. The goal of the vocational assistance was a direct employment program in light retail sales or retail department management.

On April 10, 1987, Dr. Litchman completed a physical capacities form indicating that claimant was capable of sitting for 6 hours out of a normal 8-hour work day, standing for 1 hour and walking for 1 hour. She was restricted from doing any bending or lifting in excess of 15 pounds.

A Determination Order issued May 14, 1987, which awarded claimant 20 percent unscheduled permanent disability.

Claimant began a personal job search in May 1987. She was looking for work predominantly in retail sales. Her search involved sending out letters of application accompanied by Dr. Litchman's April 10, 1987 physical capacities form. She was unable to develop any job leads.

On June 6, 1987, Dr. Litchman reviewed a job analysis for light retail sales and indicated that claimant was immediately released for such employment.

However, claimant refused to sign a return-to-work plan in light retail sales because the low end of the expected return-to-work salary range for such a position commenced at the minimum wage rate. On June 11, 1987, claimant's vocational assistance was terminated on the basis that claimant refused to cooperate in the development of a return-to-work plan.

Claimant was examined by Dr. Turco, psychiatrist and

neurologist, on September 9, 1987.

Claimant is 59 years of age. She graduated from high school in 1949 and attended one year of fashion school and one year of college in 1949 and 1950. She has extensive experience as a department store salesperson and as a motel/hotel cashier. She has a variety of skills related to those occupations which would be useful in light and sedentary work. She is currently restricted to light or sedentary work.

FINDINGS OF ULTIMATE FACT

Claimant has the physical and vocational capability to perform gainful and suitable work in light retail sales. Claimant's recovery from her compensable injury has been inhibited by psychological factors which have neither been caused nor worsened by her injury. Her impairment as a result of the compensable injury is in the upper range of mild.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Board adopts the Referee's opinion on this issue with the following comments.

Throughout her claim, claimant has complained of severely debilitating symptoms. These symptoms might be sufficient to support a finding of permanent total disability based upon medical factors alone. However, the record is essentially uniform in stating that claimant's reported symptoms far outweigh the medical findings, and, in fact, that claimant has exaggerated and prolonged her symptoms. Moreover, the only medical expert who has directly addressed this question, Dr. Turco, has concluded that claimant does not have psychological problems due to her industrial injury, but rather has a personality disorder which magnifies her physical problems. He opined that claimant has consciously or otherwise undermined efforts at resolving the problem and has refused to adjust to the reality of her limitations. Claimant's treating physician, Dr. Litchman, expressed his "total agreement" with Dr. Turco's report to this effect. We accept this nearly uncontroverted evidence. We conclude that claimant is not permanently totally disabled based upon medical factors alone.

Based upon the facts of this case, we find claimant is capable of regularly performing gainful and suitable employment. Claimant is therefore not permanently and totally disabled.

Extent of Permanent Disability

The Board adopts the Referee's opinion with regard to the extent of claimant's permanent disability.

ORDER

The Referee's order dated February 18, 1988 is affirmed. The Board approves a client-paid fee, payable from the insurer to its counsel, not to exceed $854.

KIMALENE A. HOWE, Claimant
Roger D. Wallingford, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-13456
November 8, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Leahy's order that upheld the insurer's denial of her accidental injury claim relating to her right thumb. We affirm.

ISSUE

Compensability

(1) Whether claimant has proven that her right thumb injury resulted from an on-the-job incident?

(2) If so, whether claimant's injury occurred as a result of her active participation in an assault or combat within the meaning of former ORS 656.005(8)(a)?

FINDINGS OF FACT

This case involves an altercation at work which occurred on July 31, 1987. As part of her job duties, claimant was required to use a "keying kit" for keying locks. The employer had four keying kits for the use of the employees. On the day in question, claimant removed a keying kit from the employer's hardware room and brought it to her desk. The kit which claimant took was the personal property of Harmon rather than one of the kits supplied by the employer. Harmon was in charge of the hardware room in addition to his duties keying locks. He was not claimant's supervisor. Relations between claimant and Harmon had been strained.

Upon becoming aware that claimant had his personal keying kit, Harmon approached claimant at her desk and informed her that she could not use his kit and that she would have to use a different kit. Claimant refused to turn over Harmon's kit to him because the other available kit was so disorganized as to be difficult to work with. When it became apparent that claimant would not voluntarily turn over the kit, Harmon forcibly grabbed it from her hands and returned it to the hardware room.

The ensuing events are unclear. It appears that claimant then followed Harmon to the hardware room. Words were exchanged. Claimant left the room and Harmon followed her. Claimant was very angry. Harmon wanted to straighten out the situation. Claimant told Harmon to leave her alone. When Harmon refused to leave, claimant placed her hand against Harmon's mouth and pushed. Harmon interpreted the shove as a slap and informed the receptionist that claimant had slapped him.

Shortly thereafter, claimant and Harmon confronted one another again. Claimant raised her right hand as if to strike Harmon. Harmon grabbed her hand with his own hand and pushed claimant against a partition in order to restrain her. During this struggle, claimant suffered an injury to her right thumb.

Claimant's account of the altercation is not reliable.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant to be not truthful in her testimony. We note in this regard that on the day of the altercation, claimant wrote down her account of the incident. She wrote that she "put [her] hand up to [Harmon's] mouth." However, in her deposition later, and in her testimony at hearing, claimant indicated that she merely pushed on claimant's shoulder in order to get by him and she denied touching his mouth. The statements are clearly not consistent. Moreover, by claimant's own admission and the statements of other witnesses, claimant was very agitated and angry during the incident. We agree with the Referee that claimant's recollection of the incident is not reliable.

Turning to the merits, the insurer argued alternative grounds at hearing for upholding its denial. First, the insurer argued that claimant's thumb injury did not occur during the work altercation, but instead resulted from an off-work incident. Second, the insurer argued that even if claimant did injure her thumb during the work altercation, her injury is not compensable pursuant to the so-called "aggressor defense" contained in former ORS 656.005(8)(a) (now ORS 656.005(7)(a)(A)).

With regard to the first defense, several witnesses, including Jenson who was filling out an employment application at the time, credibly testified that claimant appeared to have injured her thumb almost immediately after the incident. Although the insurer argues that claimant may have injured her thumb while water skiing earlier in the week, no persuasive evidence supports this conclusion. We conclude that claimant has proven by a preponderance of the evidence that the injury to her thumb resulted from the work altercation.

The Referee found, however, that claimant's injury was not compensable because she had been the aggressor in the altercation. The applicable statute is former ORS 656.005(8)(a), which provides, as relevant:

> "*** However, 'compensable injury' does not include injury 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."

Pursuant to the statute, four requirements must be established: (1) The claimant must be an active participant; (2) in assaults or combats; (2) which must not be connected to the job assignment; and (4) which must amount to a deviation from customary duties. Kessen v. Boise Cascade Corp., 71 Or App 545, 548 (1984). In Kessen, claimant was injured by a co-employee's punch after angrily approaching the co-employee and grabbing the co-employee's previously injured arm. The court concluded that claimant's injuries were not compensable. The Court reasoned as follows (Id. at 548):

> "Claimant was an active participant in the altercation. Although he was the recipient of the only blow struck, he was the one who, because of his anger, vocal tirade and threatening gestures, actually initiated the fight. We agree with the referee in

his characterization of claimant as being the aggressor."

Here, the grounds for finding claimant to be the aggressor are even stronger. Claimant took, and refused to return, Harmon's property. She actually struck the first blow which, we find, was something between a shove and a slap to Harmon's mouth. The credible evidence establishes that claimant was extremely angry throughout the confrontation, whereas Harmon was relatively calm throughout. In addition, we accept Harmon's testimony to the effect that his goal in approaching claimant following the initial confrontation was to try to explain his position to her, not to physically confront her. Further, the injury to claimant's thumb was the direct result of the struggle which ensued following her threatening Harmon by again raising her right hand as if to strike him.

Moreover, the claimant's conduct in striking Harmon once and threatening to strike him again clearly constitutes an "assault" within the meaning of the statute.

The assault was not connected to claimant's job assignment any more than the assault in Kessen, supra, was connected to the truck driver's job assignment there. Finally, claimant's altercation with Harmon was clearly a deviation from her normal job duties. We conclude that claimant did not sustain a compensable injury. Former ORS 656.005(8)(a).

ORDER

The Referee's order dated February 25, 1988 is affirmed. A client-paid fee, payable from the insurer to its counsel, not to exceed $1,766, is approved.

BILLY J. McADAMS, Claimant
Hollander & Associates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 87-15975
November 8, 1989
Order on Reconsideration

Claimant has requested reconsideration of that portion of our October 27, 1989 Order on Review that declined to award an assessed fee for services rendered on review for successfully prevailing against the self-insured employer's appeal from a Referee's order setting aside its denial of claimant's psychological condition. We declined to award an attorney fee because claimant's counsel had not filed a statement of services. Enclosing a statement of services for his counsel's efforts at the hearing and on Board review, claimant seeks an attorney fee for services rendered at the hearing and Board level.

Where claimant finally prevails in a hearing before the Referee or in a review by the Board, the Referee or Board shall allow a reasonable attorney fee. ORS 656.386(1). Furthermore, if a request for Board review is initiated by a carrier, and the Board finds that the compensation awarded to claimant should not be disallowed or reduced, the carrier shall be required to pay to claimant or claimant's attorney a reasonable attorney fee in an amount set by the Board. ORS 656.382(2).

Statements of services are due within 15 days of the conclusion of the proceeding and within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(a), (d)

(Repealed and replaced by OAR 438-15-028, April 1, 1989, WCB Admin. Order 2-1989). When a statement of services has been untimely submitted, we have proceeded to address attorney fee requests, provided that we retained jurisdiction over the merits of the case. Marie C. Walsh, 41 Van Natta 777 (1989).

Here, claimant is entitled to an attorney fee for prevailing against the employer's denial at the hearing level and for successfully defending the Referee's order on Board review. See ORS 656.386(1); 656.382(2). He acknowledges that his counsel has failed to comply with the aforementioned Board rules concerning the submission of statements of services. Despite claimant's omissions, since we still retain jurisdiction over the merits of the case, we proceed to consider the attorney fee requests.

After review of the statements of services and considering the factors set forth in OAR 438-15-010(6), we award a reasonable assessed fee for services at the hearing and on Board review of $3,700, to be paid by the employer.

Accordingly, our October 27, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 27, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

EMMA L. PRUITT, Claimant — WCB 87-07455
Malagon, et al., Claimant's Attorneys — November 8, 1989
Nancy Marque (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Gruber's order that set aside its denial of claimant's occupational disease claim for her psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant was required to do work on short notice and she had difficulty meeting deadlines. Claimant had no one to assist her if she could not complete her work and she was required to perform receptionist duties in that person's absence.

ULTIMATE FINDINGS OF FACT

Claimant experienced real events and conditions during her employment which were capable of producing stress when viewed objectively. These events and conditions were the major contributing cause of claimant's mental disorder.

CONCLUSIONS OF LAW

The Referee concluded that claimant met her burden of establishing that her work activities were the major contributing cause of her occupational disease. We agree.

To determine the compensability of a mental stress claim, four questions must be asked: (1) What were the "real" events and conditions of claimant's employment? (2) Were those real events and conditions capable of producing stress when viewed "objectively", even though an average worker might not have responded adversely to them? (3) Did claimant suffer a mental disorder? (4) Were the real, stressful events and conditions the "major contributing cause" of claimant's mental disorder? McGarrah v. SAIF, 296 Or 145 (1983); Leary v. Pacific Northwest Bell, 67 Or App 766 (1984); see Elwood v. SAIF, 67 Or App 134 (1984); SAIF v. Gygi, 55 Or App 570, 574, rev den 292 Or 825 (1982).

The Referee found that, in 1978, the school district hired a new superintendent who became claimant's supervisor. Claimant's duties included attending board and budget meetings and typing minutes prior to the next meeting. Claimant was also a personal secretary to the superintendent and was often given last minute jobs to complete.

Claimant and other witnesses testified that she was required to do work on short notice and that she had trouble meeting deadlines. She had no back-up at work and was required to perform receptionist duties if the receptionist was not there.

In McGarrah, the Court gave examples of events and conditions that, from an objective standpoint, existed in reality. A worker's inability to keep up with the pace of the job and the pressure of an executive or management position are two examples of real stress. McGarrah, 296 Or at 164. Also, see Betre A. Melles, 41 Van Natta 434 (1989) (Long working hours objectively capable of producing stress).

SAIF acknowledges that claimant's secretarial position was capable of causing stress. However, characterizing claimant's secretarial position as "typical", SAIF suggests that the stress was "ordinary." McGarrah offers no distinction between "ordinary" and "extraordinary" stress. Thus, the relevant question remains whether the real events and conditions were capable of causing stress. After conducting our review of the lay and medical evidence, we answer the aforementioned question in the affirmative.

Dr. Brown, claimant's treating psychiatrist, concluded that claimant suffered from a major affective disorder, depression. SAIF also concedes that the claimant suffered from anxiety, but contends that it did not arise out of her work. Based upon the lay evidence and the opinion of claimant's treating psychiatrist, we find that claimant suffered from a mental disorder.

Finally, the worker must prove that employment conditions, when compared to non-employment conditions, were the "major contributing cause" of the mental disorder. McGarrah, 296 Or at 166.

SAIF first contends that claimant's injury is not compensable because her anxiety resulted from her anticipation of returning to work (after taking a leave for unrelated surgery), rather than from conditions of employment. SAIF relies on Elwood v. SAIF, supra, where a stress claim was found not compensable

because the stress resulted from actual or anticipated unemployment. We find Elwood to be distinguishable.

Unlike Elwood, claimant was not experiencing stress as a result of actual or anticipated unemployment. Instead, claimant's anxiety was an ongoing event, attributable to over two years of a continuing series of stressful events and conditions which occurred during her employment. Consequently, we disagree with SAIF's assertion that claimant's anxiety about returning to work represents a non-work related stressor.

Alternatively, SAIF argues that even if anxiety about returning to work is work-related, the on-the-job stressors were not the major contributing cause of claimant's psychological condition. SAIF points to claimant's divorce (four years prior to her claim), to her separation from a male roommate and to her recent surgery as being the major contributing causes of her condition.

The Referee concluded that, although there was a temporal relationship between claimant's separation from her roommate and her seeking psychiatric treatment, the treating doctor, Dr. Brown, was in the best position to provide an opinion as to the cause of her condition. The Referee noted that, while both doctors who examined the claimant were well-qualified, claimant's doctor examined and treated her over an extended period of time, while Dr. Holland, who conducted an independent medical examination, only examined claimant on one occasion. We agree with the Referee's reasoning.

Although Dr. Brown was aware of the circumstances of claimant's possible off-the-job stressors, he still concluded that it was the on-the-job stressors that were the major cause of her need for treatment. In addition to finding Dr. Brown more persuasive than Dr. Holland, the Referee also based his conclusion on the credible testimony of claimant at the time of the hearing. We agree with the Referee, and conclude that under the circumstances, claimant's on-the-job stressors were the major cause of her need for treatment. Her condition is therefore compensable.

ORDER

The Referee's order dated April 25, 1988, is affirmed. For services on review, claimant's attorney is awarded a a reasonable assessed fee of $650, to be paid by the SAIF Corporation.

NORMAN A. VANDYKE, Claimant
Vick & Gutzler, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 87-08915
November 8, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee St. Martin's order that upheld the insurer's "de facto" denial of his medical services claim for low back surgery. In addition, claimant has requested that the Board remand this case to the Referee for the admission and consideration of further documentary evidence.

The Board affirms the order of the Referee.

ISSUES

1. Whether remand is appropriate.

2. Whether claimant's claim for low back surgery is a reasonable and necessary medical service related to his compensable injury.

FINDINGS OF FACT

Medical Services

Claimant, 39 at the hearing, has a history of low back problems. In May, 1977, Dr. Nash, claimant's treating surgeon, performed an L4-5 discectomy and L5 laminectomy. A few weeks later, claimant returned to regular work as a concrete finisher. He apparently worked without difficulty until approximately 1980, when he began to experience a recurrence of low back pain. He returned to Nash, who recommended further surgery. In August, 1980, Nash performed an L5-S1 discectomy and laminectomy. As before, claimant returned to regular work within a few weeks.

In 1984, claimant began working as a truck driver and salesman for a lumber yard. On August 15, 1985, he sustained a compensable low back injury. He apparently returned to work the next day. On August 21, 1985, he was examined by Dr. Tilden, a chiropractor, who diagnosed a mild lumbosacral strain. Tilden treated with chiropractic adjustment and physiotherapy for approximately one month.

Claimant continued to work at the lumber yard until December, 1985. Thereafter, he worked briefly as a welder, cabinet maker, painter, and concrete finisher. In March, 1986, he returned to Dr. Tilden with complaints of increasing low back pain. Again, Tilden treated claimant for approximately one month.

In July, 1986, claimant was reexamined by Dr. Nash. In the following three months, he underwent a CT scan, myelogram, repeat CT scan, and a MRI of the cervical spine. In October, 1986, he was examined by Dr. Berkelely, a neurosurgeon, and Dr. Waller, a microneurosurgeon.

In December, 1986, Dr. Nash requested authorization from the insurer to perform surgery on claimant's low back. The following month, the insurer informed Nash, by written letter, that it would not authorize the requested surgery.

In April, 1987, claimant underwent an MRI of the lumbar spine. A few days later, he was examined by the Orthopaedic Consultants.

In July, 1987, claimant was examined by Dr. Pace, a chiropractor.

Remand

The hearing convened on January 11, 1988. The record was left open at the close of the hearing for telephonic closing arguments. On February 1, 1988, the record was closed and on February 11, 1988, the Referee issued his Opinion and Order.

On March 8, 1988, claimant apparently underwent a CT

scan. Dr. Nash has apparently authored two medical reports of March 3, 1988, and April 14, 1988.

Claimant seeks to submit the results of claimant's CT scan and the two additional reports of Dr. Nash into evidence.

ULTIMATE FINDINGS OF FACT

Surgery is not reasonable and necessary for the compensable condition.

CONCLUSIONS OF LAW

Remand

The Board may remand a case to the Referee if it determines that the record has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5).

Here, claimant seeks remand to submit further documentary evidence into the record and to have the Referee reconsider the medical services question. We do not find the record was improperly, incompletely or otherwise insufficiently developed or heard by the Referee. In fact, the Referee left the record open for several days beyond the date the hearing closed. After being advised by the parties that "nothing further would be submitted," the Referee closed the record.

Accordingly, we are not persuaded that remand is appropriate.

Medical Services

A worker is entitled to reasonable and necessary medical services for the disabling results of a compensable injury, even if preexisting problems contribute to the disability. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); James v. Kemper Insurance Co., 81 Or App 80, 84 (1987); see ORS 656.245(1).

Here, the medical evidence is divided on the question of whether Dr. Nash's proposed low back surgery is a reasonable and necessary medical service. Drs. Nash and Berkeley recommend surgical intervention. Dr. Waller and the Consultants are of the opinion that further surgery is not warranted.

Claimant has undergone several diagnostic studies. The initial CT scan revealed:

> "IMPRESSION: No definite disc herniation. Prior laminectomy, L5 eccentric to the left. No definite evidence of nerve root entrapment."

The cervical MRI study concluded: "IMPRESSION: NO SIGNIFICANT CERVICAL SPINE ABNORMALITIES ARE SEEN." Finally, the lumbar MRI study showed:

> "IMPRESSION: FINDINGS AT THE L5-S1 AREA ARE COMPATIBLE WITH PREVIOUS SURGERY BUT THE EXTRADURAL IMPRESSION UPON THE LEFT

SIDE OF THE THECAL SAC THAT EXTENDS UP OVER THE DORSUM OF THE VERTEBRA COULD REPRESENT SCAR AND/OR RECURRENT DISC. THE FINDINGS AT THE L4-5 REGION APPEAR MINIMAL." (Emphasis added).

Although we generally assign great weight to the opinion of a worker's treating physician, in this case, we find persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). That is, the only remarkable finding from the above diagnostic tests is the possibility of a recurrent disc at the L5-S1 level. Yet, Dr. Nash proposes to operate at L4-5. (Ex. 43). Although Dr. Berkeley concurs with Nash insofar as recommending surgery, he is of the opinion that surgery should take place at the L5-S1 level. (Ex. 48). Thus, Nash is the only physician recommending surgery at L4-5.

Moreover, aside from the disagreement between Drs. Nash and Berkeley concerning the appropriate location for surgical intervention, both the Consultants and Dr. Waller opine that the diagnostic studies do not support further surgery. (Exs. 47-7, 50-2, 54-21). After reviewing the medical evidence, we are persuaded by the well reasoned opinion of Dr. Waller. See Somers v. SAIF, 77 Or App 259 (1986). Waller testified:

> "[Claimant] doesn't have anything on his x-rays that would lend itself to a successful outcome. It is a regrettable situation of a man who has persistent complaints but unless there is something that one can identify anatomically on these sophisticated studies that is a bone herniation or narrowing of the spinal canal, I don't think he is going to get better. I don't doubt the capabilities of Dr. Nash or Barkley [sic] to get him through the operation, but that isn't the question. It is: can he improve? I don't think so."

Accordingly, on this record, we agree with the Referee's conclusion that the requested authorization for low back surgery is not a reasonable and necessary medical service.

ORDER

The Referee's order, dated February 11, 1988, is affirmed.

ROBERT S. WATERSTON, Claimant — WCB 87-02554
Merrill Schneider, Claimant's Attorney — November 8, 1989
Anne Kelley, Assistant Attorney General — Order on Review

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Howe's order that declined to rate the extent of claimant's permanent disability and declined to assess penalties and attorney fees for alleged unreasonable claims processing by the Department of Justice, adjusting agent for the Inmate Injury Fund (Fund). Claimant has also submitted copies of emergency room and x-ray reports not otherwise in the record. We treat this submission as a request

for remand to the Referee for the taking of additional evidence. On review, the issues are remand, jurisdiction, claims processing, permanent disability, penalties and attorney fees. We reverse in part and affirm in part.

FACTS

On December 27, 1986, claimant, an Oregon State Penitentiary inmate, compensably injured his right hand, while working at the prison farm annex. He did not return to work the day of the injury. He reported the injury to his supervisor, shortly after the injury occurred. He was first seen at the prison hospital and later obtained emergency room treatment at a local hospital. The diagnosis was right thumb fracture. Following the hospital examination, claimant's right hand was wrapped and splinted for approximately four days.

Claimant filed an accident report with his supervisor on the date of injury. A prison nurse prepared the initial medical report, on January 5, 1987, and sent it to the Fund. The report indicated claimant was not medically stationary, but had been released to regular work. The nurse reported that no permanent impairment was anticipated.

On January 26, 1987, the Fund sent claimant a notice entitled: "NOTICE OF NONDISABLING CLAIM ACCEPTANCE AND INITIAL DETERMINATION OF AWARD." The notice informed claimant that his claim had been accepted and classified as nondisabling and closed without compensation. The form also contained a paragraph advising claimant of his hearing rights if he objected to the nondisabling claim determination. Claimant made a timely request for hearing. At the hearing, claimant exhibited some evidence of right hand impairment resulting from the fractured right thumb.

FINDINGS OF ULTIMATE FACT

The record has not been improperly, incompletely or otherwise insufficiently developed. The emergency room and x-ray reports were obtainable with due diligence at the time of hearing.

Claimant's condition was not medically stationary at the time the Notice of Closure was issued. The issuance of the Notice of Closure was unreasonable.

OPINION AND CONCLUSION

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. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986).

Here, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. There is sufficient medical and lay evidence concerning the initial determination award in the record from which to make a decision. Moreover, claimant has not shown that these submitted

materials, each of which is dated some 11 months prior to the hearing, were not obtainable with due diligence at the time of the hearing.

The Referee addressed claimant's entitlement to permanent disability rating and the propriety of penalties and attorney fees for the Fund's alleged unreasonable claims processing. The Referee determined that he could not rate claimant for disability because ORS 655.520(2) provides that an injured inmate's disability can only be determined at the time of the inmate's release from prison. We disagree.

An inmate or the beneficiary of the inmate may obtain review of action taken on the claim as provided in ORS 656.283 to 656.304. ORS 655.525. Here, in direct response to the Fund's acceptance of his claim as nondisabling and the closure of his claim, claimant requested a hearing. Since claimant was seeking review of an action taken on his claim, he is entitled to be heard. In this respect, his disagreement with the Fund's claims processing is not unlike that of a worker who is disenchanted with a carrier's notice of claim closure and requests a redetermination. See ORS 656.268(3)(e).

ORS 655.520(2) provides that, upon the inmate's release from confinement, the inmate's initial disability award shall be reaffirmed or modified. Since, pursuant to ORS 655.515(1), none of the disability benefits granted by the initial award were payable until the inmate's release, the Fund contends that the aforementioned provisions mean that the initial award is effectively interim in nature and that the Hearings Division lacks jurisdiction to consider the matter.

Because ORS 655.525 clearly permits an inmate to obtain review of an action on the claim, we disagree with the Fund's contention. We interpret the "initial award" requirements of ORS 655.520(1), as creating an obligation on the part of the Fund to declare whether the claim is disabling or nondisabling. By virtue of ORS 655.520(2), this initial assessment may be altered at the time of the inmate's release. For example, assuming that the inmate's condition was medically stationary on release from confinement, the Fund would then proceed to rate the extent of temporary and permanent disability, if any. On the other hand, if the inmate's condition was not medically stationary on release, the Fund would provide temporary disability benefits until claim closure was appropriate.

Here, following claimant's emergency room treatment, his hand was wrapped and splinted for approximately four days. Furthermore, the nurse's January 5, 1987 report notes that claimant had been released for regular work. The report was dated some nine days after the compensable injury. Finally, the nurse reported that claimant's condition was not medically stationary. These circumstances establish claimant's entitlement to temporary disability compensation for, at a minimum, four days. ORS 655.520(1); 656.210(3). Accordingly, we conclude that the injury was disabling. See ORS 655.505(3); 656.005(7)(b).

Turning to the extent of permanent disability issue, we find that claimant's condition was not medically stationary at the time of hearing. In reaching this conclusion, we note the absence of further medical reports since the issuance of the prison

nurse's January 5, 1987 report, which indicated that claimant's condition was not medically stationary. Inasmuch as claimant's condition has not become medically stationary, it would be inappropriate to rate the extent of permanent disability, if any, attributable to the compensable injury. See generally, ORS 656.268(3), (4). Consequently, the claim is remanded to the Fund for the issuance of an award when claim closure is appropriate. See ORS 655.520(2).

Finally, the Referee found that claimant had established the Fund's misconduct in handling the claim. Yet, because there was no compensation "due and owed" claimant, the Referee reasoned that no penalties could be assessed. The Referee further held that he could not assess attorney fees against the Fund since ORS 656.262(10) and ORS 656.382 authorize attorney fee assessments only against insurers or self-insured employers.

Attorney fees are awardable under ORS Chapter 655. See Johnson v. SAIF, 267 Or 299 (1973); State of Oregon v. Spear, 94 Or App 677 (1989); Richard T. Bryant, 40 Van Natta 1802 (1988). Furthermore, considering the rationale expressed in the aforementioned cases, we conclude that attorney fees for unreasonable claims processing are likewise recoverable.

We do not consider the Fund's decision to classify the claim as nondisabling to be unreasonable. At the time of the Fund's determination, the only report submitted indicated that claimant was released to regular work and that no permanent impairment was anticipated. In addition, at that time there was no indication that claimant had been unable to work. Since ORS 655.520(2) required an initial award upon the Fund's approval of the claim, we do not find the Fund's decision to categorize the claim as nondisabling based on the aforementioned report to have been unreasonable.

Nevertheless, as previously noted, the report stated that claimant was not medically stationary. Therefore, claim closure was premature. This closure was unreasonable based on the medical reports available. The effect of this closure was not final, however, as it was only an initial award subject to re-evaluation upon the inmate's release from this institution. Nonetheless, such premature closure could affect claimant's right to benefits and is clearly contrary to ORS 656.268(3). Consequently, penalties and attorney fees are warranted.

ORDER

The Referee's order dated November 20, 1987 is reversed in part. The claim closure is set aside and the claim is remanded to the Department of Justice, as adjusting agent for the Inmate Injury Fund, for further processing in accordance with law. Claimant's attorney is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed $750. Claimant is awarded a penalty of $500. Claimant's attorney is entitled to an assessed fee of $200. The remainder of the Referee's order is affirmed.

ALBERT L. WILSON, Claimant
Pozzi, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-13411
November 8, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Howell's order which: (1) upheld the self-insured employer's denial of claimant's medical services claim for surgery on his low back; (2) found that the April 14, 1987 Determination Order had not closed his claim prematurely; (3) declined to grant permanent total disability; and (4) increased claimant's unscheduled award for a low back injury from 45 percent (144 degrees), as awarded by the Determination Order, to 70 percent (224 degrees). Claimant further requests that we remand the case to the Referee for consideration of new evidence. On review, the issues are compensability, premature closure, extent of permanent disability, and remand. We affirm the Referee and decline to remand the case.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

The requested surgery is not reasonable and necessary as a result of his compensable low back injury.

Claimant was medically stationary on April 14, 1987.

As a result of his compensable injury, claimant has sustained a permanent loss of earning capacity equal to 70 percent.

The record has not been improperly, incompletely, or insufficiently developed.

CONCLUSIONS OF LAW

We adopt the conclusions of law as set forth in the "Conclusion" portion of the Referee's order, with the following supplementation.

Claimant has requested that we remand this case to the Referee for consideration of two documents. The first is a November 9, 1987 letter from the employer to claimant, terminating claimant's employment pursuant to a labor agreement. The second, is a post-operative report from Dr. Bert, claimant's treating orthopedist. If we remand this case, the employer has also requested consideration of a vocational report, which terminated claimant's vocational assistance.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, it must be shown that material evidence was not obtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986).

In regard to the November 1987 letter from the employer to claimant, we find that it was unobtainable prior to the hearing as it was not generated until after the hearing. We conclude,

however, that the content of the letter is not material to a determination of claimant's permanent disability as it existed at the time of hearing. Accordingly, remand is not merited. See Linda L. Carroll, 40 Van Natta 1095, 1097 (1988).

In regard to the post-operative report from Dr. Bert, we again find that it was unobtainable prior to the hearing as the surgery did not take place until after the hearing. We conclude, however, that the report is cumulative and does not constitute grounds to require remand. The sole reason for Dr. Bert's recommendation of surgery was for relief of pain. The Referee found, and we agree, that claimant did not experience as much pain or have as severe limitations as he represented to all physicians who examined him, including Dr. Bert. Dr. Bert's post-operative report indicates that claimant's subjective pain complaints have subsided.

After conducting our review of this matter, we are persuaded that the present record, without the inclusion of Dr. Bert's report, is sufficiently developed in regard to the issue of reasonableness and necessity of the requested surgery. Accordingly, this document does not establish that the record was improperly, incompletely, or otherwise insufficiently developed. Claimant's request for remand is denied. As we have denied claimant's request for remand, we do not reach the employer's alternative request for remand.

ORDER

The Referee's order dated October 15, 1987 is affirmed. A client-paid fee, not to exceed $2,264, is approved.

RONALD L. CANTER, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Acker, Underwood & Smith, Defense Attorneys
Mitchell, Lang & Smith, Defense Attorneys
Meyers & Terrall, Defense Attorneys
Schwenn, Bradley, et al., Defense Attorneys

WCB 85-10160, 86-05754, 86-05463, 86-05753 & 86-17036
November 9, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of those portions of Referee Tenenbaum's order that: (1) upheld Scott Wetzel Services' denial of his aggravation claim for a back condition; and (2) declined to award claimant's attorney an assessed fee for services rendered prior to the issuance of an order under former ORS 656.307. Claimant also requests an assessed fee for services on Board review.

The issues are aggravation, including the propriety of the Referee's ruling on this issue, and attorney fees.

We reverse.

FINDINGS OF FACT

Claimant has a history of low back problems, dating back to a compensable injury with Scott Wetzel's insured in November 1983. Claimant subsequently went to work for a second employer, insured by the SAIF Corporation. In July 1985, he experienced a flare-up of low back pain and filed claims with Scott Wetzel and

SAIF. Scott Wetzel issued a denial of both compensability and responsibility on August 9, 1985.

Claimant then went to work for a third employer, also insured by SAIF. In October 1985, he experienced another flare-up of back pain while working for that employer. SAIF accepted the flare-up as a new injury. Several months later, in December 1985, claimant experienced yet another flare-up of back pain while working for a fourth employer, insured by Crawford and Company.

On April 7, 1986, Crawford and Company denied responsibility for claimant's December 1985 flare-up. On April 14, 1986, SAIF denied responsibility for claimant's July 1985 and October 1985 flare-ups. On that same date, SAIF requested designation of a paying agent regarding claimant's flare-ups in July, October and December 1985.

Claimant's attorney filed hearing requests on the denials issued by Scott Wetzel, SAIF and Crawford and Company. An order pursuant to former ORS 656.307 issued on May 14, 1986. Under the terms of that order, all three insurers agreed that responsibility was the only issue in contention. Prior to the issuance of that order, claimant's attorney assisted the various insurers to clarify facts and issues.

In September 1986, claimant experienced yet another flare-up of back pain while working for a fifth employer, also insured by SAIF. On November 12, 1986, SAIF formally denied responsibility for the flare-up on behalf of that employer.

Claimant's various hearing requests were consolidated and heard in one proceeding. Responsibility and attorney fees were the only issues raised and litigated by the parties at hearing.

FINDINGS OF ULTIMATE FACT

Claimant's attorney was instrumental in protecting claimant's right to compensation prior to issuance of the ".307" order on May 14, 1986 .

CONCLUSIONS OF LAW AND OPINION

Aggravation Ruling

The Referee assigned responsibility for claimant's current condition to Scott Wetzel, and set aside its denial insofar as it applied to continuing medical services. However, the Referee upheld the denial insofar as it applied to disability compensation. The Referee premised the latter ruling on her finding that claimant had not demonstrated a worsening of his underlying condition.

On review, claimant contends that he has demonstrated a compensable worsening of his condition. We, instead, conclude that the Referee's ruling was beyond the scope of the issues raised at hearing and should be reversed on that ground. As a party to the March 1986 ".307" order, Scott Wetzel conceded compensability of claimant's aggravation claim. It did not reassert a compensability issue at hearing. As a result, that issue was not, raised at hearing. Accordingly, the Referee erred in upholding Scott Wetzel's aggravation denial.

Attorney Fee at Hearing Level

Claimant contends that the Referee erred in declining to award an attorney fee for services rendered prior to the issuance of the May 1986 ".307" order. We agree.

Assessed fees for services at the hearing level are authorized under ORS 656.386(1). Under that provision, claimant is entitled to a reasonable carrier-paid fee for finally prevailing in a "rejected case," defined as a case in which entitlement to receive compensation, as opposed to the amount of compensation, is at issue. Short v. SAIF, 305 Or 541, 545-546 (1988); Rhonda L. Bilodeau, 41 Van Natta 11 (1989). Compensability of claimant's claim with Scott Wetzel was finally resolved with the issuance of the May 1986 ".307" order. Nevertheless, claimant's attorney is entitled to an attorney fee, payable by Scott Wetzel, if he rendered services protecting claimant's compensation prior to issuance of that order.

The Referee declined to award an attorney fee because she was not persuaded that claimant's attorney had rendered services in furtherance of the .307 order, or had otherwise been instrumental in obtaining benefits for claimant. We disagree. Scott Wetzel's August 9, 1985 denial was of both compensability and responsibility, and it would have become final if claimant's attorney had not filed a hearing request on the denial. Prior to issuance of the ".307" order some nine months after Scott Wetzel's denial, claimant's attorney assisted the various insurers to clarify facts and issues. We conclude that claimant's attorney is entitled to a fee for these services under ORS 656.386(1), payable by Scott Wetzel. See former OAR 438-47-015; Donald D. Davis, 40 Van Natta 2000 (1988); Ronald L. Warner, 40 Van Natta 1082, 1194 (1988).

Attorney Fee on Board Review

Finally, claimant contends that his attorney is entitled to a carrier-paid fee, payable by Scott Wetzel, for services on Board review regarding the Referee's aggravation ruling. We agree.

As discussed above, ORS 656.386(1) authorizes a reasonable carrier-paid fee for finally prevailing in a case in which the employer or carrier contests entitlement to compensation. Short v. SAIF, supra; Rhonda L. Bilodeau, supra. As a result of the Referee's ruling, claimant was required to litigate the compensability issue on Board review. We recognize that Scott Wetzel conceded compensability of claimant's aggravation claim when it joined the May 1986 ".307" order. We also recognize that it made no attempt to relitigate that issue at hearing. Nevertheless, it took the position on Board review that the Referee's ruling should be affirmed, and it submitted a brief in support of that position. Under these circumstances, we find that claimant's attorney is entitled to an attorney fee on Board review under ORS 656.386(1), payable by Scott Wetzel.

ORDER

The Referee's order dated February 26, 1987 is reversed in part and affirmed in part. Scott Wetzel Services' denial is set aside in its entirety, and the claim is remanded to Scott Wetzel for processing according to law. Claimant's attorney is awarded a

$300 assessed fee for services rendered prior to the issuance of the ".307" order, payable by Scott Wetzel Services. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an additional $500 fee for services on review regarding the Referee's aggravation ruling, payable by Scott Wetzel. The Board approves a client-paid fee for counsel for Scott Wetzel, not to exceed $348.50. The Board approves a client-paid fee for counsel for Crawford and Company, not to exceed $176.

JAMES C. CONAWAY, Claimant
Rex Q. Smith, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-03789
November 9, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Bethlahmy's order which: (1) upheld the insurer's partial denial of claimant's medical services claim for diabetes and chest pains; (2) awarded claimant's attorney $600, rather than the greater sum, sought for his efforts in evoking the insurer's recission of a subsequent denial of claimant's medical services claim for a quadricep biopsy. On review, the issues are compensability and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Claimant has not made a medical services claim for diabetes and chest pains.

CONCLUSIONS OF LAW

The Referee upheld the insurer's partial denial of claimant's diabetes and chest pains. The Referee's decision was based on the lack of a causal relationship between those conditions and either claimant's employment or previous compensable back injury. Although we agree that there is no causal relationship, the record does not establish that claimant made a claim for such conditions. Accordingly, the denial was issued prematurely.

In the present case, the insurer issued a denial of claimant's diabetes and chest pains on the basis that those conditions were not related to his employment or prior compensable back condition. The denial notes that the insurer was "in receipt of medical information that [claimant] received care for diabetes and chest pains." The medical information that the insurer relied upon, however, is not in the record. Instead, there is a short memorandum, dated approximately 8 months after the denial, from Dr. Sonneland which states inter alia:

> "I have been treating [claimant] for medical problems including diabetes mellitis since May, 1986. Based on my information there is no causal relationship between his diabetes and his back claim."

Although Dr. Sonneland states that she has been treating claimant for diabetes, there is no evidence in the record that any

medical bills for such treatment, or medical reports/chart notes referencing such treatment, were presented to the insurer prior to the denial. Although it is conceivable that such materials were presented to the insurer, the record is silent on this issue.

Under some circumstances, a "precautionary" denial issued by an insurer is proper. See Johnson v. Spectra Physics, 303 Or 49, 57 (1987); Sidney M. Brooks, 38 Van Natta 925, 926 (1986). In the instant case, however, there is no evidence that a claim was ever made for diabetes and chest pains; therefore, any denial of those conditions would be premature. Alvin H. Despain, 40 Van Natta 1823. Accordingly, the denial must be set aside as premature.

In regard to the attorney fee awarded to claimant's attorney for obtaining a recission of the March 10, 1987 denial, we adopt the Referee's "Conclusions and Reasons."

ORDER

The Referee's order dated October 20, 1987, as amended October 26, 1987, is reversed in part and affirmed in part. That portion of the order which upheld the January 14, 1987 denial is reversed and the denial is set aside as premature. For his efforts at hearing and on Board Review concerning this issue, claimant's attorney is awarded a reasonable assessed fee of $200. A client-paid fee, not to exceed $952, is approved.

RICHARD A. AEH, Claimant
Becker & Hunt, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-10687
November 13, 1989
Order on Reconsideration

The insurer requested reconsideration of that portion of our October 3, 1989, Order on Review, which affirmed the Referee's assessment of a $400 assessed attorney fee for its allegedly unreasonable delay in disclosing certain photographs. In order to consider the insurer's request, we abated our order, on October 24, 1989, and allowed claimant 10 days to respond. Having received claimant's response, we have reconsidered the attorney fee matter.

ORS 656.262(10) provides for the assessment of an attorney fee under ORS 656.382(1), which, in turn, allows for an attorney fee when an insurer or self-insured employer "unreasonably resists the payment of compensation." Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). Here, although the insurer unreasonably delayed disclosing certain photographs, its delay did not result in any resistance to the payment of compensation. Accordingly, on this record, an attorney fee under ORS 656.382(1) is not assessable and we were incorrect to affirm the Referee's award of such a fee in our October 5, 1989 Order on Review.

After withdrawing our prior order and reconsidering the attorney fee mater, we reverse that portion of the Referee's order that assessed an attorney fee for the insurer's delay in disclosing certain photographs; otherwise, we affirm the Referee's order. We, therefore, adhere to and republish our order of October 5, 1989, as amended herein.

IT IS SO ORDERED.

RICHARD D. CONLEY, Claimant
W.D. Bates, Jr., Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-06962
November 13, 1989
Order on Review

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Huffman's order that: (1) awarded 10 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the right foot; and (2) found claimant to be medically stationary on June 2, 1986, thereby reducing his temporary partial disability as awarded by a Determination Order. Claimant seeks the admission of additional documents as new exhibits. We treat such a request as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985). The self-insured employer cross-requests review, contending that the permanent disability award should be reduced or eliminated. We affirm.

ISSUES

The issues on review are extent of permanent disability, entitlement to temporary partial disability, and remand.

FINDINGS OF FACT

Claimant suffered a compensable injury to his right foot on September 24, 1985. He was working as an offbearer on the green-chain when a large cant fell on his right foot, breaking the distal second metatarsal and the proximal aspect of the second digit. He was treated by Dr. Griffith, osteopath, and returned to work seven weeks after the accident. After working for a few days, claimant suffered swelling and discomfort and was taken off work.

He then started treating with Dr. Roy, foot specialist, who prescribed an orthotic walking device. He was able to return to work on a limited basis but continued to report pain and numbness. Dr. Roy prescribed acupuncture in April, 1986, to reduce discomfort. On June 2, 1986, Dr. Roy declared claimant to be medically stationary and predicted that he would have difficulty working on his feet for more than two or three hours at a time.

Claimant has suffered loss of joint plantar flexion of the second toe of his right foot. He has sustained permanent loss of use or function of the right foot in the minimal range.

Claimant was medically stationary on June 2, 1986.

CONCLUSIONS OF LAW AND OPINION

Remand

Under the rules in effect at the time of hearing,(former OAR 438-07-005(4)), the employer's attorney should have transmitted to claimant a list of documents the employer intended to offer at hearing. When the employer did not provide such a list, claimant's attorney filed with the Referee his own list of documents.

At hearing, the employer sought to introduce 32 exhibits. Claimant objected, pointing out that the employer

should have filed a list of these documents twenty days prior to hearing. The employer argued that claimant was not prejudiced because he already had each document and requested the Referee to find that the employer had shown good cause for not meeting the twenty-day deadline. The Referee found that employer did not have good cause, and he did not admit any of the documents.

Subsequently, claimant sought to introduce certain of the documents previously objected to and excluded. The Referee declined to admit the documents and declined to allow claimant to use them for impeachment.

Claimant has now attached two documents to his brief on review; we treat such material as a motion to remand. Judy A. Britton, supra. We decline to remand. To merit remand, it must be shown that the evidence submitted on review was not obtainable with due diligence at the time of hearing. Delfina P. Lopez, 37 Van Natta 164 (1985). No such showing has been made.

In this case, claimant's attorney had all the evidence now submitted prior to hearing and objected to some of it when offered by the employer. Claimant successfully resisted the introduction of evidence by the employer, and then later wished to use the same evidence to establish an affirmative point. Considering claimant's prior objections at hearing, we conclude that he cannot now retract those complaints.

Extent of Permanent Disability

The Referee awarded claimant 10 percent scheduled permanent disability for his right foot condition. The employer cross-appeals this award, arguing that the evidence shows no permanent disability.

Claimant was examined by Dr. McHolick, orthopedist, at the request of the employer and reported a loss of 20 degrees range of motion in claimant's second toe on his right foot. This medical evidence places claimant's permanent impairment in the minimal range. Dr. Roy's testimony indicates that claimant will have life-long difficulty working on his feet for extended periods. We agree with the Referee that the evidence supports an award of 10 percent scheduled permanent partial disability.

Claimant is entitled to a carrier-paid fee for prevailing against the employer's cross-request. ORS 656.382(2); Kordon v. Mercer Industries, 308 Or 290 (1989). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, since we have not received a statement of services from claimant's attorney, we are unable to award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order dated October 15, 1987, is affirmed. A client-paid fee, not to exceed $882, is approved.

JANE B. PARVIS, Claimant
C. Douglas Oliver, Claimant's Attorney
Thomas Sheridan (SAIF), Defense Attorney

WCB 86-14725
November 13, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Lipton's order that declined to set aside a Disputed Claim Settlement ("DCS"). On review, the issue is whether the DCS should be set aside.

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

At the time claimant signed the DCS, she had sufficient mental capacity to enter into a contract. She has not shown that she entered into the agreement as a result of duress. She was represented by counsel and was fully aware that there was medical evidence both for and against her claim. There has been no showing that either the employer or the SAIF Corporation misrepresented her work history to the independent medical examiners. There has been no showing of mutual mistake of fact between the parties nor actual or constructive fraud perpetrated against claimant.

Claimant has failed to prove extraordinary circumstances which would justify setting aside the DCS. We reject claimant's argument that the doctrine of collateral estoppel applies in this case.

ORDER

The Referee's order, dated March 17, 1988, is affirmed.

WAYNE A. RATHMAN, Claimant
Diane Gruber, Claimant's Attorney
Deborah L. Sather, Defense Attorney

WCB 86-09817
November 13, 1989
Order on Review

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of those portions of Referee Uffelman's order which assessed a penalty and associates attorney fee for an unreasonable denial. We reverse.

ISSUES

The sole issue is whether the insurer was unreasonable in denying the claim for depression based on the information it had at the time of the denial.

FINDINGS OF FACT

Beginning in 1981, claimant was subject to stress while working for this employer. Dr. Weitgarner has been claimant's treating psychiatrist since 1981. Claimant saw Dr. Weitgartner for depression in January 1986. Claimant stopped working on January 21, 1986. Dr. Weitgartner filed a form 827 on April 29, 1986. He diagnosed depression with explosive behavior and checked a box indicating the condition was work-related. He noted that claimant was complaining of false accusations at work which he could not judge the veracity of.

The insurer denied the claim on June 17, 1986. It based

its denial on its belief that work activities were not the major cause of claimant's condition. It alleged that the major causes were personal problems such as his brother's death and his wife's cancer.

At the time of the denial, the employer believed that claimant had left his job in January for a better job. It was also aware of the death of claimant's brother and claimant's wife's cancer.

CONCLUSIONS

The Referee concluded that the denial was unreasonable because it was not supported by any medical evidence. We disagree.

At the time of the denial, the treating physician had opined that the depression was work-related; he had not opined that work was the major cause of the depression. Furthermore, he acknowledged that his opinion was based on claimant's version of the facts which he could not judge. Furthermore, claimant had quit work for the employer and then filed a claim several months later. Finally, the employer was aware of off-the-job stressors which could have contributed to a depression. Under these circumstances, we conclude that it was not unreasonable for the employer to doubt the compensability of the claim and to deny it.

ORDER

The Referee's order dated November 10, 1987 is reversed in part. Those portions which assessed a penalty and attorney fee are reversed. The Referee's order is affirmed in all other respects. A client paid fee, not to exceed $700, is approved for the insurer's.

KATHLEEN A. RODABAUGH, Claimant	WCB 88-01610
Durham, et al., Claimant's Attorneys	November 13, 1989
Stafford J. Hazeltte, Defense Attorney	Order on Review

Reviewed by Board Members Cushing and Myers.

Claimant requests review of those portions of Referee Neal's order which: (1) declined to find that her temporary total disability benefits had been improperly reduced and then terminated on March 14, 1988; and (2) declined to assess a penalty and fee for unreasonable resistance to the payment of compensation.

ISSUES

The first issue is whether the insurer improperly reduced claimant's temporary total disability benefits to temporary partial disability benefits beginning January 5, 1988.

The second issue is whether the insurer improperly progressively reduced the rate of temporary partial disability benefits from January 20, 1988 through March 13, 1988.

The third issue is whether the insurer improperly terminated claimant's temporary disability benefits on March 14, 1988.

The final issue is whether claimant is entitled to a

penalty and associated attorney's fee for the insurer's allegedly unreasonable resistance to the payment of temporary disability compensation.

FINDINGS OF FACT

Claimant compensably injured her low back on September 21, 1987. Dr. Mason began treating claimant in November 1987. Dr. Mason released claimant to part-time work as of December 1, 1987.

Claimant returned to part-time work on December 1, 1987. She worked approximately four hours with pain. She was then suspended by her employer for reasons unrelated to her compensable injury.

On December 31, 1987, the employer sent claimant a letter along with "a performance contract." The letter stated that if claimant did not sign the contract, the employer would consider claimant to have voluntarily quit. The contract required claimant to acknowledge that she was guilty of misconduct on the job. Claimant refused to sign the contract.

The insurer reduced claimant's benefits from temporary total disability benefits to temporary partial disability benefits as of January 5, 1988. Dr. Mason continued to report that claimant was capable of returning to part-time work throughout January and February 1988. At one point, after talking with the employer, he reported that claimant could gradually increase her work hours.

The insurer gradually reduced the amount of temporary partial disability benefits throughout January and February 1988. By March 14, 1988, the insurer terminated temporary disability benefits altogether.

On March 1, 1988, Dr. Mason reported that claimant had been unable to work from January 20, 1988. Claimant then began seeing Dr. Valleroy. Dr. Valleroy stated on March 14, 1988 that claimant was significantly disabled. Claimant was unable to work at that time.

CONCLUSIONS AND OPINION

Once claimant returned to part-time work, the insurer was justified in reducing her temporary total disability benefits to temporary partial disability benefits based on the difference between her regular wage and the wage she earned working part-time. ORS 656.212; OAR 436-60-030(3). Once claimant actually returned to part-time work, the insurer was justified in paying temporary partial disability benefits at the rate established until she became unable to work due to her injury. Even though claimant left work, she left work for reasons unrelated to her injury; therefore, the insurer was justified in paying temporary partial disability benefits until claimant became unable to work due to her injury. See Safeway Stores v. Owsley, 91 Or App 475 (1988). Therefore, the insurer was justified in paying claimant only temporary partial disability benefits beginning January 5, 1988.

However, we conclude, based on Dr. Mason's March 1, 1988 report, that claimant became totally unable to work due to her

injury on January 20, 1988. Thus, claimant was substantively entitled to receive temporary total disability benefits from January 20, 1988 on. Inasmuch as that substantive entitlement was not established until March 1, 1988, the insurer was procedurally correct in paying temporary partial disability benefits at the rate established by deducting claimant's part-time rate from her full time rate until the insurer learned that claimant was totally disabled. At that point, the insurer should have retroactively paid claimant the amount she was substantively entitled to.

However, rather than paying temporary partial disability benefits at the proper rate, the insurer gradually reduced the temporary partial disability payments until it terminated them completely. We find no justification for this action and conclude that it amounts to an unreasonable resistance to the payment of compensation. Furthermore, the insurer was without any reasonable justification for totally terminating temporary disability benefits. Claimant had never returned to regular work; neither had she been released to regular work and declared medically stationary. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

The Referee concluded that the insurer's actions were correct except that it should have reinstated claimant to temporary total disability benefits as of March 14, 1988. She assessed no penalty or associated attorney's fee. Consequently, we modify the Referee's order.

ORDER

The Referee's order of May 11, 1988 is modified. The insurer shall pay claimant the proper rate of temporary partial disability benefits, based on the difference between her full-time wage and the amount she would have earned working part-time had she continued to work part-time, from January 5, 1988 through January 19, 1988. The insurer shall pay to claimant temporary total disability benefits from January 20, 1988 until such benefits are properly terminated according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The insurer shall pay to claimant, as a penalty, an amount equal to 25 percent of the additional compensation awarded herein. Claimant's attorney is awarded $1,125 as an attorney fee associated with the penalty.

PAUL T. RUMREICH, Claimant
Francesconi, et al., Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney
Rankin, et al., Defense Attorneys
Carl M. Davis, Assistant Attorney General

WCB 87-06980, 86-10144 & 86-13825
November 13, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Raymond Clapp, an alleged noncomplying employer, requests review of that portion of Referee Leahy's order that set aside the SAIF Corporation's denial of claimant's industrial injury claim relating to his right wrist. Claimant cross-requests review of those portions of the order that upheld a denial issued by the SAIF Corporation on behalf of another alleged noncomplying employer, Joseph Keyes. We reverse on the request for review and affirm on the cross-request.

ISSUES

1. Whether claimant was an independent contractor, an employee of Raymond Clapp or an employee of Joseph Keyes on the date of his injury.

2. If claimant was an employee of Clapp or Keyes, whether the employer was subject to the Workers' Compensation Law.

3. If so, whether claimant sustained a compensable injury.

4. If so and if claimant was an employee of Clapp, whether Keyes is responsible for claimant's injury under former ORS 656.029.

FINDINGS OF FACT

Claimant accidentally lacerated his right wrist on February 28, 1981 while clearing brush on a small piece of property owned by Joseph Keyes. Keyes, a retired engineer, had purchased the property a few days before claimant's injury and planned to have a house built on it for resale on the real estate market. After purchasing the property, Keyes asked Raymond Clapp, a licensed general contractor, to clear it. Clapp, in turn, offered this work to claimant.

Clapp had performed two other construction projects for Keyes during late 1980 and early 1981. The first was the remodeling of a beach home for Keyes' personal use. The second was the construction of a guest house for the personal use of members of Keyes' family. Clapp billed Keyes for labor and materials twice per month during the course of these projects. Keyes also authorized Clapp to charge some materials on Keyes' account at a lumber yard. In addition to his work for Keyes, Clapp was performing construction work for other persons during this period.

Claimant approached Clapp in February 1981 after learning through friends that Clapp might be able to provide work for him. The two had never worked together previously. They tentatively agreed that claimant would be paid at a rate of $6 per hour. Clapp then contacted Keyes and asked him if he had any objection to claimant performing the clearing work. He estimated that the total labor cost for the job would be about $50. Keyes voiced no objection to this arrangement.

Clapp instructed claimant to meet him at a certain coffee shop before 8 o'clock on the morning of February 28, 1981. Claimant did so and then followed Clapp to the job site. On the way, the two stopped at Clapp's tool shed and Clapp retrieved a brush cutter for claimant's use that day. At the job site, Clapp instructed claimant to clear the property of brush and blackberry vines, but to leave any trees standing. He also told claimant to pile whatever he cut at a certain place on the lot and burn it. He left claimant a can of gasoline for this purpose. He then went to another location, leaving claimant alone. Claimant's injury occurred about an hour and a half later. Because of the injury, claimant was unable to continue clearing the lot. The job was later completed in about an hour by a man named Bob Harn.

Before his injury, claimant hoped that his relationship with Clapp would be ongoing. Clapp, however, had given claimant no indication that more work would be available for him after he finished clearing Keyes' lot.

On May 12, 1981, Keyes formed a corporation called Arch Cape Development, Inc. for which he obtained workers' compensation coverage through SAIF. Keyes hired Clapp as a construction foreman for Arch Cape Development and also hired claimant as a laborer after claimant had recovered from his injury. On August 14, 1981, Keyes and Clapp paid claimant $900 in exchange for a release of all claims relating to claimant's February 1981 injury. Several years later, in January 1986, claimant consulted an attorney and learned that a release of a workers' compensation claim is void. He then filed claims against Clapp, Keyes and Arch Cape Development, Inc. These claims were denied by SAIF.

At the hearing, the parties stipulated that no injury occurred to claimant after he began working for Arch Cape Development and that his claims against that entity were erroneous. Neither Clapp nor Keyes had workers' compensation insurance at the time of claimant's February 1981 injury.

FINDINGS OF ULTIMATE FACT

1. On the date of his injury, claimant was a worker of Raymond Clapp. He was not a worker of Joseph Keyes.

2. Claimant's employment with Clapp was casual and Clapp did not employ any other subject employees. Clapp was not a subject employer.

CONCLUSIONS OF LAW

1. Claimant's Employment Status

One element which claimant must prove to establish entitlement to workers' compensation is that he was a "worker" within the meaning of former ORS 656.005(28) (now subsection (27)) at the time of his injury. That subsection defines "worker" as "any person . . . who engages to furnish services for a remuneration, subject to the direction and control of an employer." This definition requires application of a "right to control" analysis and, if that is inconclusive, of a "nature of the work" test. Woody v. Waibel, 276 Or 189, 196-97 (1976); Henn v. SAIF, 60 Or App 587, 593 (1982), rev den 294 Or 536 (1982).

The principal factors in the "right of 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. Henn v. SAIF, supra, 60 Or App at 591. Clapp exercised control over the details of claimant's work including the time that claimant would start, the method by which he would cut the brush and the way in which he would dispose of the brush. The evidence regarding the method of payment was conflicting. Claimant testified that the agreement was that he would be paid at an hourly rate. Clapp testified that the agreement was that claimant would be paid a lump sum of $50. He also testified that he paid claimant the $50 on the job site just before claimant began work because claimant had complained of financial difficulty. We find claimant's testimony on this point

more plausible. Clapp provided all of the equipment which claimant used to perform the job. There is no definitive evidence regarding the fourth factor. Under these circumstances, we conclude that the evidence establishes an employment relationship between claimant and Clapp under the "right to control" test. In view of this, we need not examine the relationship under the "nature of the work" test.

We also conclude that claimant was not employed by Keyes. Keyes exercised no control over claimant's work other than to approve Clapp's hiring of claimant. We find no significance in this approval because it was sought by Clapp; there is no evidence that it was required by Keyes. The relationship between Keyes and Clapp was clearly one of property owner and independent contractor. Clapp and not Keyes, therefore, controlled claimant's work and was claimant's employer. SAIF's denial of claimant's claim against Keyes must be upheld on that basis.

2. Clapp's Status as a Subject Employer

Another element which claimant must prove to establish entitlement to workers' compensation is that Clapp was a "subject employer." "Subject employer" is defined by ORS 656.023 as "[e]very employer employing one or more subject workers in the state." "Subject worker," in turn, is defined by ORS 656.027. That section states that all workers are subject except those expressly designated as nonsubject. Subsection (3) of ORS 656.027 applies in the present case. At the time of claimant's injury, it designated as nonsubject:

> "(3) A worker whose employment is casual and either:
>
> "(a) The employment is not in the course of the trade, business or profession of the employer; or
>
> "(b) The employment is in the course of the trade, business or profession of a nonsubject employer."

The subsection went on to define as "casual" those "employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200."

Claimant's employment was "casual" within the meaning of the above definition. He was hired by Clapp to work for a single day at a rate of $6 per hour. The total labor cost for claimant for an 8 hour day, therefore, would be $48. There is some evidence that Clapp may have employed another worker named Bob Harn during late 1980 and early 1981. (See Tr. 83-84). However, this testimony is insufficient to establish that Harn was an employee of Clapp.

Given the record as developed in this case, we conclude that claimant's employment with Clapp was casual and that Clapp did not employ any other subject workers. Clapp, therefore, was not a subject employer within the meaning of ORS 656.023 and was not required to provide workers' compensation coverage for claimant. See Bisbey v. Thedford, 68 Or App 200, 203 (1984);

Konell v. Konell, 48 Or App 551, 557-58 (1980), rev den 290 Or 449 (1981). SAIF's denial of claimant's claim on behalf of Mr. Clapp is upheld on that basis.

In view of the above conclusion, the compensability and responsibility issues are moot.

ORDER

The Referee's order dated February 23, 1988, as amended March 16, 1988, is affirmed in part and reversed in part. Those portions of the order that set aside SAIF's denial on behalf of Raymond Clapp dated April 27, 1987 and awarded claimant's attorney an attorney fee of $1,700 are reversed. SAIF's denial on behalf of Mr. Clapp is reinstated and upheld. The Referee's ruling regarding the compensability of claimant's claim is also reversed as moot. The remainder of the Referee's order is affirmed.

ADELBERT P. SHEPPARD, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys

WCB 85-01687, 85-01769 & 85-01770
November 13, 1989
Order on Review (Remanding)

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Leahy's order on remand, which dismissed his request for hearing for failing to comply with discovery rules. We remand.

ISSUES

1. Whether the Referee allowed claimant 10 days to respond to the motion for dismissal.

2. Whether the Referee was correct in re-dismissing claimant's request for hearing.

FINDINGS OF FACT

Claimant filed a November, 1984, claim for bilateral hearing loss with multiple employers. Each employer denied the claim. In February, 1985, he timely requested a hearing. In April, 1986, the Referee issued an "Order on Motion" requiring claimant to allow the other parties unrestricted access to his treating physicians. The order further indicated that if claimant did not comply, the employers could move for dismissal of his request for hearing. See former OAR 438-06-085; new OAR 438-06-071(1)).

On August 5, 1986, one of the employers moved for dismissal of claimant's hearing request. In its motion, the employer asserted that claimant's physician had refused to talk with it without the presence of claimant's attorney. On August 11, 1986, the Referee issued an Order of Dismissal on the grounds that claimant had not complied with the "Order on Motion." Claimant requested Board review of the dismissal order.

The Board issued an Order on Review (Remanding), dated August 27, 1987. The case was remanded to the Referee on the basis that he did not allow claimant adequate time to respond to the

dismissal motion. That is, the Referee incorrectly dismissed claimant's hearing request only six days after the employer's motion to dismiss, whereas former OAR 436-06-045 allowed 10 days for a response to a pre-hearing motion. Adelbert P. Sheppard, 39 Van Natta 747 (1987).

By way of a letter, dated November 18, 1987, the Referee informed the parties that:

> "The Board by its August 27, 1987 Order remanded these cases to the referee to allow claimant 10 days to respond to AIAC's motion the Board has ordered that once the response is received the referee may then consider AIAC's motion to dismiss the hearing request.
>
> Please comply with the Board's order."

On December 4, 1987, the Referee issued a Dismissal Order on the basis that no response had been received pursuant to the Board's Order on Review, or pursuant to his November 18, 1987 letter.

The Referee properly allowed claimant 10 days to respond to AIAC's dismissal motion. The record is insufficiently developed, however, to support either of the Referee's dismissal orders.

CONCLUSIONS OF LAW

10-day Procedural Matter

Claimant argues that the Referee's letter of November, 1987, did not order him "to respond within any period of time." We disagree.

Although the Referee's November, 1987, letter was not a model of clarity, it complied with the Board's August, 1987, remand order. First, the Board remanded to the Referee to allow claimant 10 days to respond to the employer's dismissal motion. The Referee did so. His letter specifically stated that claimant is allowed "10 days to respond to [the employer's] motion * * *." Second, the Board's August, 1987, order -- with its instructions to allow a response period of 10 days -- was expressly referenced in the November, 1987, letter. Last, the Referee actually allowed well beyond 10 days before entering his December, 1987, dismissal order.

Propriety of Referee's Dismissal Orders

Notwithstanding our finding above, we must proceed to analyze whether the Referee was correct in dismissing claimant's request for hearing. In other words, the fact that claimant did not respond within 10 days of the Referee's November, 1987, letter, did not absolve the Referee -- as the trier of fact -- from determining whether dismissal was appropriate. An order of dismissal should not be issued without any evidence in support of the dismissing party's argument. Here, it was.

Consequently, we are unable to determine whether

claimant, in fact, obstructed AIAC's opportunity to speak ex parte with Dr. Milligan. Other than the multitude of written arguments and motions that have been submitted by the parties, there is no record in this case. Neither testimony nor exhibits have been admitted into evidence.

We may remand for "further evidence taking, correction or other necessary action[,]" when the record had been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, inasmuch as the only "evidence" before us is in the form of written arguments, we conclude that the record is not sufficiently developed.

Accordingly, we remand to the Referee with instructions to address and resolve the issue of whether claimant obstructed AIAC's right to speak ex parte with Milligan at, and before, the time of the original dismissal order dated August 11, 1986, not subsequent thereto. If the Refeee who initially heard this matter is no longer available, the Assistant Presiding Referee for the Portland office is directed to assign this case to another Referee. The Referee who hears this case shall decide the obstruction issue after a record has been opened and evidence submitted. This may be done in any manner that will achieve substantial justice, as determined by the Referee, after considering the respective positions of the parties.

ORDER

The Referee's order, dated December 4, 1987, is vacated and this matter is remanded to the Referee to carry out the instructions consistent with this order.

NYALL W. BACON, Claimant
Max Rae, Claimant's Attorney
Edward C. Olson, Defense Attorney

WCB 87-03758
November 14, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Huff's order which awarded an attorney's fee out of compensation rather than a carrier-paid fee.

ISSUES

The sole issue is when an attorney is instrumental in reinstating vocational rehabilitation without a hearing whether he is entitled to a carrier-paid fee or a fee payable out of claimant's compensation.

FINDINGS OF FACT

The facts are not in dispute. The carrier referred claimant to a vocational rehabilitation counselor. The counselor terminated vocational services based on alleged non-cooperation. Claimant's attorney requested that the carrier assign a new vocational rehabilitation counselor. The carrier did not do so. Claimant's attorney requested a conference with the Rehabilitation Review Division (RRD).

Claimant, claimant's attorney, a representative of the carrier and a representative of RRD met in a conference on

March 6, 1987. At the conference, the carrier agreed to reinstate claimant's vocational assistance.

CONCLUSIONS

At hearing, claimant requested that the Referee assess a carrier-paid fee for his services in connection with obtaining reinstatement of claimant's vocational assistance. The Referee denied the request, reasoning that this situation was not covered by ORS 656.386(1) because termination of vocational assistance is not the type of "denial" which would trigger a carrier-paid fee under ORS 656.386(1). Rather, he concluded this case is one of the "other cases" covered by ORS 656.386(2) which allows only fees payable out of claimant's compensation. He reasoned that this case does not involve a "denial" because the termination of vocational assistance was done by the vocational provider rather than by the carrier itself.

Claimant argues that this case is covered by ORS 656.386(1) because vocational assistance is compensation, the carrier's agent has, in effect, denied compensation and claimant's attorney has been instrumental in having compensation reinstated.

We disagree with the Referee that the dispositive question is who terminated vocational services. The insurer is responsible in the first instance for determining eligibility for vocational services. We also disagree with claimant that he is entitled to a carrier-paid fee because the termination of vocational services amounts to a denial of compensation.

Claimant's attorney is only entitled to a carrier-paid fee if causation is in issue; where the amount of compensation due is the sole issue, the fee must come from claimant's increased compensation. Ohlig v. FMC Marine & Rail Equipment, 291 Or 586 (1981). We conclude that the question of entitlement to further vocational services is a question of extent of benefits. Accordingly, claimant's attorney is only entitled to a fee out of compensation. For this reason, we affirm the Referee.

ORDER

The Referee's order, dated October 29, 1987, is affirmed.

DANIEL L. LEEK, Claimant	WCB 89-06949
Popick & Merkel, Claimant's Attorneys	November 14, 1989
Abigail Herman (SAIF), Defense Attorney	Order on Reconsideration

On November 6, 1989, in accordance with the SAIF Corporation's withdrawal of its request for review, we issued our Order of Dismissal. Claimant has requested a carrier-paid fee for prevailing against SAIF's appeal of the Referee's order.

The request is denied. Where a carrier's request for Board review is dismissed prior to our review, claimant is not entitled to an attorney fee. Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Matthew W. Johnson, 40 Van Natta 393 (1988); Rodney C. Strauss, 37 Van Natta 1212, 1214 (1985).

Accordingly, our November 6, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

FRANCES MARTINEZ, Claimant
Merrill Schneider, Claimant's Attorney
Stafford Hazelett, Defense Attorney

WCB 87-04195
November 14, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Higashi's order which set aside its denial of chiropractic treatments in excess of two times per month. On review, the sole issue is reasonableness and necessity of treatment. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings" and make the following additional finding.

On March 9, 1987, the insurer issued a denial stating, "[W]e are hereby denying further chiropractic treatment above two times per month. The bills which precede the date of this denial will be honored, but further treatment above this amount will be returned to your physician."

FINDINGS OF ULTIMATE FACT

The insurer's March 9, 1987 denial was addressed to no service rendered. It was entirely prospective in nature.

CONCLUSIONS OF LAW

The Referee concluded that chiropractic treatment in excess of two times per month is reasonable and necessary as a result of claimant's compensable injury and set aside the insurer's denial. Although we agree with the Referee that the denial should be set aside, we modify his reasoning.

A claim for medical services is generally made in the form of a medical billing or a request for authorization of treatment addressed to the carrier. Billie J. Eubanks, 35 Van Natta 131 (1983). A denial of care in the future is void; and any denial of treatment in reliance on such a denial must be set aside. Evanite Fiber Corporation v. Striplin, ___ Or App ___ (November 8, 1989); Robert M Bryant, 41 Van Natta 324 (1989).

Here, the insurer accepted all claims for medical services through the date of the denial. The denial purports to address all post-March 9, 1987 chiropractic treatment. The denial can only be read as a denial of future medical benefits. Accordingly, the denial must be set aside as prospective. Striplin, supra; Bryant, supra.

ORDER

The Referee's order dated October 1, 1987 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $400 for services on review, payable by the insurer.

DIANE L. SIMMONS, Claimant
Horton & Koenig, Claimant's Attorneys
Daryl E. Klein, Defense Attorney

WCB 86-08257
November 14, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Tenenbaum's order which upheld Royal Insurance's denial of claimant's occupational disease claim for an upper back and neck condition. Royal cross-requests review, contending that claimant's claim is barred because of res judicata. The issues on review are jurisdiction, compensability and responsibility.

We affirm.

FINDINGS OF FACT

Claimant had a compensable neck and upper back injury on December 26, 1980, while the SAIF Corporation was on the risk. The claim was accepted and processed as nondisabling. SAIF's coverage of the employer ceased on December 31, 1981. Royal Insurance began insuring the employer on February 1, 1982 and continued until the end of 1984. In the years following the 1980 compensable injury, claimant had continuing exacerbations of the neck and upper back condition.

On April 11, 1983, while Royal was on the risk, claimant suffered a compensable hernia injury. Royal accepted the claim. Claimant had two surgeries for the hernia. A May 14, 1984 Determination Order awarded 10 percent (32 degrees) unscheduled permanent disability.

During the approximately nine months that claimant did not work because of her hernia injury, she did not have any neck or back symptoms.

Claimant returned to work in June 1984 for the same employer, but could no longer work as a courier. She worked as a telephone clerk. As telephone clerk she often held a phone between her neck and shoulder.

Around September 1984, claimant's neck and back problems again became symptomatic. She had difficulty turning her neck. She sought treatment on November 12, 1984 for the neck and back problems. Her treating physician, Dr. Rubadue, a chiropractor, took her off work for one week. Claimant advised her employer that she was having neck and back problems. She terminated her employment in November 1984 after her physician advised her she would be unable to return to her clerk position due to the neck/back condition.

Claimant's work activities as a telephone clerk caused an exacerbation of the the pain associated with the 1980 compensable injury. Because of continuing neck and back pain, claimant pursued an aggravation claim against SAIF. SAIF denied the claim. Claimant requested a hearing.

In December 1984, claimant and Royal entered into a stipulated agreement whereby claimant was awarded an additional 5 percent (16 degrees) unscheduled permanent disability for her hernia. The stipulation also provided that "no claim has been made for any of claimant's neck, shoulder or upper back complaints

which are the subject of a December 1980 injury under SAIF coverage." At the time of the December 1984 stipulation, claimant had made no claim for her neck and back problems against Royal.

The aggravation claim against SAIF went to hearing in 1986. On March 31, 1986, a prior Referee upheld SAIF's denial of claimant's aggravation claim; in so doing, he indicated that he believed claimant had a viable occupational disease claim against Royal. However, Royal was not a party to that proceeding. The order was not appealed.

Claimant filed this occupational disease claim against Royal in April 1986. Royal denied the claim on the ground that the notice of accident was not timely filed with the employer. Royal later issued a second denial, stating that claimant's condition had occurred when it was not on the risk and that claimant was barred from bringing a claim because the matter had been settled by the December 18, 1984 stipulation.

At hearing, counsel for Royal described the issues as follows:

> "The claim is late. It's an occupational disease claim. Number two, it relates back to the original injury. It's an aggravation of the original injury in 1980; and number three, which is the strongest defense, is that this claim is barred by res judicata." Tr. 1

In his opening statement, counsel for Royal made the same contentions. Tr. 6-8.

The Referee's order upheld the denial for the reason that claimant did not establish a compensable injury.

FINDINGS OF ULTIMATE FACT

Royal did not issue a written denial of compensability of claimant's occupational disease claim.

Royal did not raise the issue of compensability at hearing.

Claimant had not filed an occupational disease claim for the neck and back conditions at the time the parties entered into the December, 1984 stipulation.

Claimant was disabled due to the neck and upper back disease on November 9, 1984. Claimant's work activity with Royal could have caused claimant's disease.

SAIF's 1980 injury remained a material contributing cause of claimant's worsened neck and upper back condition in November, 1984.

Work exposure while Royal was on the risk did not independently contribute to claimant's worsened neck and upper back condition.

CONCLUSIONS OF LAW AND OPINION

Timeliness of the claim

Royal denied the claim on the ground that notice of the

accident was untimely under ORS 656.265(1). At hearing, Royal instead argued that claimant cannot prevail on her occupational disease claim because she did not file her claim within the time prescribed by former ORS 656.807. Tr. 8-9. Neither contention was directly addressed by the Referee. Neither is argued on review. Therefore, we do not address them.

Res Judicata

At hearing, Royal contended that claimant's occupational disease claim against Royal is barred by res judicata. Royal argued that the claim was disposed of by the December 1984 stipulation.

The Referee rejected the contention. She relied on Carr v. Allied Plating Co., 81 Or App 306 (1986) and Lawrence N. Sullivan, 39 Van Natta 88 (1987), rev'd in part 91 Or App 413 (1988). She concluded that the hernia and back claims were not part of a single cause of action, and that the back claim had not been litigated nor been ripe for litigation at the time of the stipulation. Accordingly, the Referee reasoned that the stipulation's "raised or raisable" language did not dispose of the disease claim. We agree and adopt the Referee's reasoning.

On review, Royal also argues claimant could have joined it as a party in the SAIF litigation and her failure to do so bars a later filing against Royal. We disagree.

The rule claim of preclusion cannot be based on failure to assert a claim in a previous litigation by one who was not a party to the first litigation. Restatement (Second) of Judgments § 17 (1982); Million v. SAIF, 45 Or App 1097, 1101-02, rev den 289 Or 337 (1980).

Compensability

The Referee upheld Royal's denial on the ground that claimant did not establish a compensable occupational disease. Royal defends the order on that basis. An occupational disease claim is compensable if work activity in all employment is the major cause of the disease. A claim filed with a particular employer is not noncompensable because claimant does not establish that that employment was an actual cause of the disease. Bracke v.Baza'r, 293 Or 239 (1982). Therefore, Royal's denial on the basis that exposure at SAIF caused the disease was not a denial of compensability. Because Royal did not deny compensability and did not raise that issue at hearing, the Referee erred in addressing that issue.

Responsibility

As compensability of the neck and upper back conditions was conceded, we must address responsibility.

Royal contends that, although claimant's work at its insured was capable of causing the renewed disability, it in fact did not. It contends that it may avoid responsibility by proving that claimant's worsened disability was solely caused by claimant's 1975 SAIF injury. Ordinarily, an employer may not rely on the rules governing responsibility as a defense unless other

potentially responsible employers have been joined. Runft v. SAIF, 303 OR 493, 504 (1987). Royal has not joined SAIF, the insurer it contends is responsible. Nevertheless, under the circumstances of this case, Royal may assert a responsibility defense.

Claimant chose to bring her aggravation claim for her back condition against SAIF. Royal Insurance was not made a party to that proceeding. Claimant took that action knowing full well that Royal was potentially responsible for her back condition. Claimant went forward with her claim and did not prevail. The Referee's order upholding SAIF's denial has become final by operation of law.

Because SAIF, the insurer to whom the evidence suggests responsibility should be assigned, has earlier prevailed in a proceeding involving a claim for precisely the same condition, the claim is precluded by res judicata. Therefore, we conclude that Royal is permitted to defend on the basis of the last injurious exposure rule, its failure to join SAIF notwithstanding.

Responsibility for an occupational disease is assigned, in the first instance, to the employer at the time the condition became disabling, provided that employment was capable of causing the condition. Bracke v. Baza'r, 293 Or 239 (1982). Here, that insurer was Royal. Claimant's condition first became disabling on November 9, 1984. Prior to that time, claimant's condition was simply a painful condition sometimes characterized as a strain. Royal was the insurer on the risk in November 1984. Both claimant's testimony and reports from her treating chiropractor establish that at the time her condition became disabling her work was of the kind that could have produced a strain.

Nevertheless, Royal may avoid responsibility for the occupational disease by establishing that a prior accepted injury is the sole cause of claimant's disability. Boise Cascake v. Starbuck, 296 Or 238, 243-245 (1984). In this successive injury-disease context, sole cause may be established by persuasive evidence that exposure at Royal's insured did not independently contribute to a worsening of claimant's disability. We believe that Royal's proof is sufficient.

Claimant has had intermittent neck and shoulder symptoms since her 1980 injury. Claimant's treating physician, Dr. Rubadue, who was aware of claimant's post-1980 medical history and the nature and symptomatic effect of her clerk duties in 1984, has related claimant's condition to her 1980 injury. Dr. Christensen, D.C., whose opinion clearly addressed the responsibility issue, attributed the cervical condition to the 1980 injury. Dr. Duff, an independent medical examiner, noted a recent symptomatic increase, but indicated that claimant's condition had not changed. While claimant's condition clearly worsened, at least temporarily, in 1984, we conclude that exposure while Royal was on the risk did not independently contribute to claimant's condition. Therefore, Royal has established that responsibility should remain with SAIF. Claimant is, therefore, entitled to no relief.

ORDER

The Referee's order dated June 5, 1987 is affirmed.

GRACE L. STEPHEN, Claimant
Peter O. Hansen, Claimant's Attorney
Malagon & Associates, Attorneys
Norman Cole (SAIF), Defense Attorney

WCB 85-14678
November 14, 1989
Order on Remand

This matter is before the Board on remand from the Supreme Court. SAIF v. Stephen, 308 Or 41(1989). The Court has held that, before claimant is entitled to permanent total disability (PTD) benefits, she must establish that, but for the compensable injury, she: (1) is or would be willing to seek regular gainful employment; and (2) has or would have made reasonable efforts to do so. Concluding that our prior order failed to make "findings concerning whether, but for the compensable injury, the claimant would have returned to work", the Court has remanded "for further proceedings consistent with [its] opinion."

FINDINGS

Claimant was 73 years of age at hearing. She possesses a fourth grade education. Except for her work activities as a welder between 1942 and 1945, she has neither worked nor sought work outside of the home. After leaving her welding activities, claimant started raising her family, which eventually reached a total of nine children.

Claimant never had definite plans to return to work as a welder, but likewise, had no definite plans not to return to her prior work activities. Ultimately, she developed compensable laryngeal cancer, which resulted in a 1962 left vocal cord excision and a 1971 total laryngectomy. After the 1962 cancer surgery, claimant's weakness, shortness of breath, and lack of education and transferable skills prevented her from returning to work had she so desired.

Before her 1962 and 1971 surgeries, claimant had voluntarily withdrawn from the work force. Subsequent to these surgeries, we are unable to find that she was willing to reenter the work force.

Claimant also suffers from severe atherosclerotic cardiovascular disease, which is unrelated to her compensable condition. This disease caused a heart attack, which occurred approximately 14 months prior to the hearing. Standing alone, either the cardiovascular disease or claimant's cancer condition would have prevented her from returning to work, had she been so inclined. Efforts to seek work would be futile.

We are unable to find that, but for the compensable injury, claimant would have returned to work.

CONCLUSIONS

A person who voluntarily withdraws from the work force is not entitled to PTD benefits for a subsequent disability because she or he is no longer a worker, that is, no longer one who "engages to furnish services for a remuneration." SAIF v. Stephen, supra, 308 Or at page 47. Yet, removal from the work force is not necessarily a static state. Id. The Stephen court has reasoned as follows:

"A claimant may voluntarily leave the work

> force with a sincere hope of never having to return, but later decide that returning to the work force is desirable or necessary because of changed financial or personal circumstances. If such a claimant is unable to return to the work force because of a prior compensable injury, he or she would suffer lost wages at that point. Such a claimant is not barred from receiving PTD benefits solely because he or she earlier voluntarily left the work force." SAIF v. Stephen, 308 Or at 47.

Based on the aforementioned reasoning, the Court has held that a claimant who seeks to reenter the work force after voluntary withdrawal, but is prevented from doing so by a compensable injury, may qualify as a worker although not presently engaged "to furnish services for a remuneration." SAIF v. Stephen, supra.

We have previously found that claimant had voluntarily withdrawn from the work force at the time of her 1962 and 1971 surgeries. Grace L. Stephen, 39 Van Natta 1045 (1987). Our conclusion that she was not entitled to temporary total disability (TTD) benefits following these surgeries has not been altered by either appellate body. SAIF v. Stephen, 93 Or App 217 (1988), 308 Or 41, 45 (1989).

Yet, claimant's voluntary withdrawal from the work force does not end our inquiry. As noted above, a claimant who later decides to return to the work force, but is unable to do so because of a prior compensable injury, may qualify as a worker and become entitled to PTD benefits. SAIF v. Stephen, 308 Or 41, 47 (1989).

Here, pursuant to the parties' agreed statement of facts, claimant could possibly have returned to work as a welder if she had not contracted cancer. However, because of her deteriorating condition following the 1962 surgery, she did not think that she could return to the work force. There is no indication that claimant subsequently altered this judgment.

Based on these findings, we continue to conclude that claimant had voluntarily withdrawn from the work force at the time of her 1962 and 1971 surgeries. Consequently, she was not a "worker" and, as such, was not entitled to TTD nor PTD benefits during those periods. SAIF v. Stephen, supra. Furthermore, we are unable to find that claimant subsequently decided to return to the work force, which would have changed her former status as a nonworker.

Inasmuch as claimant voluntarily withdrew from the work force and did not subsequently decide to reenter the work force after her withdrawal, she never regained her status as a "worker." Since claimant is not a "worker", she is not entitled to PTD benefits. SAIF v. Stephen, supra, 308 Or at 47.

We are persuaded that, by the time of hearing, claimant was prevented from returning to work, assuming she had been so inclined, by either her noncompensable cardiovascular disease or her compensable cancer condition. Yet, we are unable to find that she is or was willing to seek regular gainful employment. At

most, the record suggests that, upon reflection, claimant had entertained the possibility of a return to work as a welder at some indefinite time prior to developing her compensable cancer. Such speculation does not lead us to the conclusion that, but for the compensable injury, claimant would have returned to work.

Accordingly, we hold that claimant is not entitled to permanent total disability benefits.

IT IS SO ORDERED.

JERRY L. WARKENTIN, Claimant — WCB 87-07171
Brian R. Whitehead, Claimant's Attorney — November 14, 1989
Merrily McCabe (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee Black's order that found that claimant had failed to perfect a claim for aggravation within the time period allowed by ORS 656.273(4). On the merits of his claim, claimant contends that he has proven a compensable aggravation. We find that claimant timely perfected a claim for aggravation, but we further conclude that he has failed to sustain his burden of proving a compensable claim.

ISSUES

1. Whether claimant timely perfected an aggravation claim?

2. If so, whether he prevails on the merits of that claim?

FINDINGS OF FACT

Claimant suffered an off-work injury to his right knee while snow skiing in late 1975 or early 1976. He subsequently underwent a lateral menisectomy. Then, a few months later, he compensably injured his right knee when he fell off a truck. In July 1976, Dr. Bert, orthopedic surgeon, performed a medial meniscectomy.

Dr. Bert performed a closing examination on November 16, 1976. Claimant had full range of motion of his knee with some crepitus under the kneecap but no instability. He reported experiencing morning stiffness. Dr. Bert restricted claimant from performing heavy work in the woods. Other than that, claimant was free to perform "all usual and accustomed work."

By Determination Order dated January 18, 1977, claimant was awarded 10 percent scheduled permanent partial disability for loss of use of the leg.

Over the next several years, claimant was employed installing insulation underneath residences. This work required considerable crawling on his hands and knees. In January 1980, he sought medical treatment from Dr. Hoda, orthopedic surgeon. Claimant reported a grinding sensation in his knee of increasing severity. Dr. Hoda noted patellar crepitation and some pain and tenderness over the lateral femoral condyles. Hoda advised that claimant lose weight, exercise his quadriceps, and avoid climbing steps or doing deep knee bend exercises. He recommended no other treatment unless the crepitation worsened.

On April 24, 1980, Dr. Hoda reported that claimant was laid off from an under-the-house insulation job because of knee pain. Examination revealed "nothing remarkable except for what he had on his last examination." Dr. Hoda recommended that claimant find a new job not requiring climbing ladders or kneeling.

Claimant next saw Dr. Spady, orthopedic surgeon, in August 1980. Dr. Spady had previously performed nonwork-related surgery on claimant's right knee. Dr. Spady reported:

> "[Claimant] now complains of snapping and grinding and aching about the region of the patella. Really, the knee looks quite good. There is no effusion present. He has a normal range of motion. There is slight crepitus of the patella on motion. * * * Probable diagnosis is chondromalacia of the patella."

Dr. Spady further reported on August 28, 1980 that he did not recommend any active treatment, other than symptomatic treatment. He felt that claimant should be encouraged to learn some new employment not requiring heavy use of his knees.

In 1983, claimant twice requested that the Board exercise its Own Motion authority to reopen his claim. Both requests were denied. Claimant again requested reopening in 1984. The Board rejected this request also. In February 1987, pursuant to a fourth request, the Board reopened claimant's claim.

We are unable to find that claimant's compensable condition worsened between January 18, 1977 and January 18, 1982.

CONCLUSIONS OF LAW AND OPINION

A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation. ORS 656.273(3). The Referee concluded that claimant had not perfected an aggravation claim. The Referee reasoned that neither the reports of Dr. Bert, Dr. Hoda nor Dr. Spady stated that additional medical services were required or that there was a worsening of claimant's knee resulting in additional loss of use or function.

We agree that the medical reports do not indicate a need for further medical services. The most that can be said of the reports is that they project a potential need for further medical services should claimant's condition worsen.

However, we find that Dr. Hoda's April 24, 1980 report makes a claim for aggravation. In that report, Dr. Hoda relates claimant's statement to the effect that he was forced off a particular job due to knee pain. Thus, the report indicates a need for additional compensation pursuant to ORS 656.273(3). We are mindful in this regard that "almost anything more than [a statement that claimant's condition is not changing] can be an aggravation claim." Haret v. SAIF, 72 Or App 668, 672 (1985).

Although we find that claimant has timely perfected an aggravation claim, he must still prove entitlement to additional compensation on the merits. To reopen a claim because of

aggravation, claimant must prove a worsening of his condition resulting from his original injury. ORS 656.273(1). In this regard, we are persuaded that claimant's knee symptoms worsened in approximately 1980 due to his activities installing insulation. However, increased symptoms in and of themselves are not compensable unless claimant becomes more disabled, either temporarily or permanently, than he was at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396, 401 (1986). Because this claim involves a scheduled body part, "more disabled" means increased loss of use of the knee. ORS 656.214; International Paper Co. v. Turner, 84 Or App 248, 250 n. 1, remanded 304 Or 354 (1987), on remand 91 Or App 91 (1988).

Expert medical evidence is generally not required to prove an aggravation claim. A claimant's own testimony may be sufficient. Garbutt v. SAIF, 297 Or 148 (1984). Here, claimant's testimony supports a finding of aggravation. However, claimant's testimony was elicited at his hearing in January 1988. Consequently, he was testifying to his condition as it existed seven-to-eight years earlier. Under the circumstances, we find the contemporaneous medical reports more persuasive than claimant's subsequent testimony.

Those contemporaneous medical reports do not establish increased loss of use or function of claimant's knee. Comparing claimant's condition in January 1977 with his condition in 1980 and 1981, claimant continued to exhibit full range of motion. He continued to experience mild crepitation. He continued to be diagnosed as suffering from probable chondromalacia. No effusion was present at either time. While Dr. Spady reported complaints of snapping and grinding in 1980, these same complaints appear in Dr. Bert's 1976 reports. Moreover, Dr. Spady, the surgeon who repaired claimant's knee following his ski injury, reported in August 1980 that claimant's knee appeared "quite good." While Dr. Hoda and Dr. Spady recommended that claimant change employments, neither physician suggests that such a change was necessitated by worsened, rather than ongoing, conditions. In light of the physician's findings, we conclude that their imposition of physical restrictions against heavy use of the knee reflects a reaction to claimant's continued complaints rather than a worsening of his condition.

In sum, we find that claimant did perfect a claim for aggravation within the time period established by ORS 656.273(4). However, we further conclude that claimant has failed to establish the compensability of his claim.

ORDER

The Referee's order dated February 11, 1988 is affirmed.

ALAN C. CHURCH, Claimant
Peter O. Hansen, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 85-04704
November 15, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Baker's order that: (1) increased claimant's scheduled permanent disability award for the loss of use or function of his left hand from 30 percent (45 degrees), as awarded by a Determination Order, to 60 percent (90 degrees); (2) declined to award unscheduled permanent partial disability for a psychological condition; (3) found that claimant's claim was not prematurely closed; (4) upheld the SAIF Corporation's November 3, 1986 aggravation denial; (5) declined to award additional temporary disability compensation; (6) declined to assess a penalty and associated attorney fees for SAIF's alleged unreasonable delay in submission of the claim for closure on two occasions; (7) declined to assess a penalty and attorney fees for an alleged unreasonable failure to pay temporary disability; (8) declined to assess a penalty and attorney fee for an alleged unauthorized offset; (9) ratified SAIF's offset of a permanent disability award granted by Determination Order against a subsequent award granted by a prior Referee's order; and (10) authorized SAIF to offset overpaid temporary disability compensation. The issues are extent of permanent disability, premature closure, aggravation, temporary disability, offset, and penalties and attorney fees. Claimant's brief was not timely submitted and, therefore, was not considered on Board review. SAIF elected not to file a respondent's brief. We affirm on all but the offset and related penalty and attorney fee issues.

FINDINGS OF FACT

Claimant, a mechanic, compensably injured his left hand on April 11, 1983, when his left thumb was caught in a spinning shaft. The injury involved a ligamentous sprain which resulted in surgery performed on May 13, 1983.

By Determination Order dated January 27, 1984, claimant was granted time loss compensation from the date of injury through December 1, 1983 and from December 15, 1983 through January 3, 1984 (less time worked). Claimant was also awarded 25 percent scheduled permanent disability for loss of function of the left hand.

Claimant challenged the January 1984 Determination Order as premature. In November 1984, the Board affirmed a Referee's order which had set aside the Determination Order. The Referee's order did not authorize an offset of permanent partial disability paid under the Determination Order against future entitlements.

Claimant was then involved in a vocational training program. SAIF notified claimant on February 4, 1985 that his vocational training had ended on January 23, 1985 and that his vocational reports were being forwarded to the Workers' Compensation Department. Approximately one month later, on March 11, 1985, SAIF requested a determination from the Department.

On March 4, 1985, claimant was examined by Dr. Shannon, psychiatrist. Dr. Shannon noted that claimant was depressed as a result of his injury, his house burning, and the fact that his

wife apparently had thoracic outlet syndrome. Dr. Shannon did not propose any treatment at that time.

The claim was closed for a second time by Determination Order dated March 28, 1985, with temporary disability benefits ending January 23, 1985, and an award of 30 percent scheduled permanent disability. Deduction of overpaid temporary disability, if any, from unpaid permanent disability was approved. The Determination Order also provided that it replaced any prior award for the same body part. The Determination Order did not authorize the offset of overpaid permanent disability compensation against the award of permanent disability.

Claimant's vocational training program was re-opened on April 1, 1985. When the training program ended, the claim was closed by a third Determination Order dated April 14, 1986. This Determination Order granted additional temporary disability benefits ending March 21, 1986, but no additional permanent disability. The Determination Order found claimant medically stationary as of July 15, 1984. The Determination Order contained no reference to authorization for recovery of any overpayment.

The 30 percent permanent disability award granted by the March 1985 Determination Order became payable following completion of claimant's vocational training program. At that time, SAIF offset the 25 percent permanent award paid pursuant to the January 1984 Determination Order, which was set aside as premature.

Following the April 1986 Determination Order, SAIF also offset overpayment of temporary disability benefits going back to 1984.

Claimant experienced an exacerbation of his thumb symptoms in May 1986 when he caught his left hand in a railing while attending classes as part of his vocational training. He went to see his treating physician a few days later. By chart note dated May 9, 1986, the physician reported that no further treatment was recommended and that claimant could return to work as of that date. Claimant's attorney forwarded a copy of the chart note to SAIF by letter dated September 9, 1986, requesting that the chart note be processed as an aggravation claim. SAIF responded by letter dated November 3, 1986 indicating that the chart note was not an aggravation claim because there was no authorization of time loss.

Claimant's thumb impairment has resulted in a loss of pinch, grasp, and repetitive motion. Moreover, claimant's use of his left hand for pushing, pulling, grasping and lifting are all substantially limited. The hand is sensitive to cold. Claimant continues to find it necessary to wear a brace much of the time, and that in itself effectively limits the practical use of the hand.

SAIF did not have authorization to offset its payments of permanent partial disability under the January 27, 1984 Determination Order against the permanent disability awarded pursuant to the March 28, 1985 Determination Order. Nor did SAIF have a reasonable basis for concluding that its offset was proper.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Claimant contends that his claim was prematurely closed by the April 14, 1986 Determination Order, which found him to be medically stationary as of July 15, 1984. Claimant argues that he was not psychologically stationary. We do not agree.

Dr. Shannon expressly found that claimant was psychologically stationary as of March 1985. In addition, while claimant treated very briefly with Dr. Eason, psychiatrist, in September 1986, Dr. Eason's report dated October 22, 1986 does not persuade us that claimant was not medically stationary on or before April 14, 1986. First, Dr. Eason only treated claimant for a two-week period. Second, the record contains only very conclusory statements regarding Dr. Eason's findings and treatment. And, finally, it is unclear from Dr. Eason's report what knowledge he had of claimant's psychological condition prior to commencing his treatment. Consequently, his report cannot be interpreted as referring to claimant's condition as of the date of claim closure. See Scheuning v. J.R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987).

We conclude that claimant has failed to establish that his claim was prematurely closed by the April 14, 1986 Determination Order.

Aggravation

Claimant contends that the May 1986 incident where he caught his hand in a railing at school resulted in a compensable aggravation. In order to establish an aggravation of his scheduled left hand disability so as to warrant claim reopening, claimant must prove that his condition is worse. ORS 656.273; Perry v. SAIF, 307 Or 654 (1989). A worsened condition means a change which makes claimant more disabled, either temporarily or permanently, than he was on the date of the last arrangement of compensation. In the context of a scheduled disability case, more disabled means increased loss of use or function of the body part. International Paper v. Turner, 84 Or App 248, 250-51, n 1, remanded 304 Or 354 (1987), on remand 91 Or App 91 (1988).

The evidence here is insufficient to persuade us that claimant experienced increased loss of use or function of his left hand as a result of the May 1986 incident. In this regard, his physician reported as follows: no change in sensation over the previous examination; tenderness (which existed at the time of the previous examination); slight swolleness; and stability on stress. The physician reported that claimant could return to work as of that date. Claimant's testimony that the incident "seems to have weakened it some" is not sufficient to persuade us of an increased loss of use, either temporary or permanent. Consequently, claimant has failed to prove a compensable aggravation.

Extent of Scheduled Permanent Disability

The criterion for rating scheduled permanent disability is the permanent loss of use or function of the body part due to the compensable condition. ORS 656.214(2). In determining loss

of use or function, we consider medical and lay evidence in light of the administrative rules. These rules are applied as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut, 296 Or 505 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). Further, in determining scheduled disability, we consider disabling pain as well as mechanical impairment. See Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980). Our factual findings with regard to claimant's left thumb and hand persuade us that claimant loss of use of the hand is moderately severe. Accordingly, we agree with the Referee that claimant has suffered a 60 percent permanent loss of use or function of the left hand as a result of the industrial injury.

Extent of Unscheduled Permanent Disability

The Referee declined to award any permanent disability benefits for claimant's psychological condition. Claimant testified that he was depressed as a result of the injury and the limitations it imposed on him. He also testified that he had difficulty concentrating on technical tasks for long periods of time. However, Dr. Shannon opined that claimant had no serious psychological problem and that he was handling things "fairly well, very much in his normal manner." She further opined that it was difficult to predict whether claimant would need treatment in the future.

We conclude that claimant has failed to establish entitlement to an award of unscheduled permanent disability for his psychological condition. We base this conclusion on the lack of persuasive medical evidence to establish any permanent loss of earning capacity from claimant's depression. Although probative, claimant's testimony, by itself, does not persuade us that he has suffered a permanent loss of earning capacity.

Interim Compensation

Even though we find that claimant has failed to establish a compensable aggravation claim, he may nevertheless be entitled to payment of interim compensation pending SAIF's acceptance or denial of his claim. In this regard, SAIF would be required to commence payment of interim compensation if the May 9, 1986 chart note represents notice of "medically verified inability to work." ORS 656.273(6). To the contrary, the May 1986 chart note indicated that claimant was able to work. Therefore, SAIF was under no obligation to commence payment of interim compensation upon its receipt of the chart note sometime after September 9, 1986.

Offset

The January 1984 Determination Order awarded claimant 25 percent scheduled permanent partial disability. SAIF paid the award. That Determination Order was subsequently set aside by referee's order as premature. The order did not authorize an offset of permanent disability benefits paid under the Determination Order against future entitlements. In March 1985 a new Determination Order awarded claimant further temporary disability and 30 percent permanent disability. The March 1985 Determination Order expressly stated that it replaced any prior award. The Determination Order did not authorize an offset of overpaid permanent disability benefits against the 30 percent awarded by the Order.

If the January 27, 1984 Determination Order had not been set aside, then the fact that the March 1985 Determination Order expressly "replaced" any prior awards would have authorized SAIF to pay only the difference between the new order and the prior order. However, because the prior Determination Order was set aside by referee's order, SAIF should have sought authorization to offset payments made before the prior Determination Order was set aside. SAIF did not do so; instead, SAIF unilaterally offset its prior payments against the new award of 30 percent permanent disability. SAIF's unilateral conduct was improper. Forney v. Western States Plywood, 66 Or App 155, 160 (1983), aff'd 297 Or 268 (1984). Consequently, the compensation which SAIF should have paid pursuant to the March 28, 1985 Determination Order, but did not, must now be paid.

In the alternative to its argument at hearing that offset authorization was unnecessary, SAIF requested authorization from the Referee to offset the amounts in question. Because of his decision that SAIF's conduct was proper, the Referee did not address the request for authorization. Whereas we have found SAIF's unilateral offset improper, SAIF's request for authorization to offset must be addressed. In this regard, we find that SAIF was entitled to an offset of permanent disability compensation paid pursuant to the rescinded January 27, 1984 Determination Order. Accordingly, SAIF's request for authorization shall be granted.

SAIF also requested authorization to offset overpaid temporary disability benefits in the amount of $823.23 for the period March 21, 1986 through issuance of the new Determination Order on April 14, 1986. The Referee granted authorization for the offset. The testimony of SAIF's claims examiner established entitlement to this offset. The Referee's authorization is, therefore, affirmed.

Penalties and Attorney Fees

(1) Untimely Closure

Claimant alleges that SAIF unreasonably delayed submitting the claim for closure on two occasions. The first occasion culminated in the March 28, 1985 Determination Order. In that instance, claimant's vocational counselor recommended to SAIF on January 31, 1985 that claimant's training program be ended. SAIF notified claimant on February 4, 1985 that his vocational training was ending, and that his vocational reports were being forwarded to the Workers' Compensation Department. However, as of February 13, 1985, claimant's vocational counselor was still attempting to continue claimant's training program. Less than one month later, on March 11, 1985, SAIF requested a determination. Under these circumstances, we find that SAIF's delay in submitting the claim for closure was not unreasonable. See Oscar L. Drew, 38 Van Natta 934 (1986).

The second occasion culminated in the April 14, 1986 Determination Order. In that instance, claimant's vocational counselor notified SAIF on March 14, 1986 that claimant's training program was ending. SAIF submitted the claim for closure on March 31, 1986. The delay was not unreasonable.

(2) Failure to Pay Interim Compensation

We have previously held that SAIF was not required to commence payment of interim compensation upon receipt of the May 9, 1986 chart note from claimant's treating physician. Therefore, the question of penalties and attorney fees for unreasonable failure to pay such compensation is moot.

(3) Unilateral Offset

Claimant requested an award of penalties and related attorney fees for SAIF's conduct with regard to the offset issue. A penalty of up to 25 percent and an associated attorney fee may be assessed against a carrier which unreasonably delays or refuses to pay compensation due. ORS 656.262(10); 656.382(1). SAIF's argument for its unilateral offset was that the January 27, 1984 Determination Order had been rescinded and, therefore, that it properly offset benefits paid pursuant to that order. As noted above, that fact that the January 27, 1984 Determination Order was rescinded establishes that SAIF is substantively entitled to an offset. However, regardless of SAIF's substantive entitlement to an offset, its obligation to request prior authorization for such an offset is clear. Forney, supra; see ORS 656.268(4). We conclude that SAIF's conduct was unreasonable and that a 25 percent penalty should be assessed on the amount of permanent disability compensation remaining unpaid on the March 28, 1985 Determination Order. We also assess a related attorney fee. See ORS 656.262(10), 656.382(1).

ORDER

The Referee's order dated May 8, 1987 is reversed in part and affirmed in part. The SAIF Corporation's offset of overpaid permanent disability compensation was unauthorized and unreasonable. SAIF shall repay claimant the amount withheld by reason of the offset. A penalty equal to 25 percent of this withheld amount and an associated attorney fee of $500 is assessed against SAIF in connection with the offset. After paying said amount, SAIF is allowed an offset of the amount withheld against future awards of permanent disability on this claim, if any. Claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

LYNN M. ELLIOTT, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-05171, 86-15343, 86-15352, 87-15114 & 87-15115
November 15, 1989
Order on Review

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Thye's order that: (1) upheld the insurer's medical services denial; and (2) declined to rate the extent of his unscheduled permanent disability for a back condition on "jurisdictional" grounds. In addition, claimant argues that the Board should remand this case to the Referee for further consideration of the extent of disability issue, inasmuch as the Referee did not make a credibility finding. On Board review, the issues are remand, medical services, jurisdiction, and extent of unscheduled disability. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

The compensable injury of April, 1986, is a material contributing cause of claimant's current back condition.

Claimant's current treatment is not reasonable and necessary treatment.

Claimant has no permanent physical impairment in his low back due to the April, 1986, compensable injury. His post-injury weight gain was not industrially related.

CONCLUSIONS OF LAW

Remand

The Board may remand a case to the Referee when it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, the sole basis for claimant's request for remand is that the Referee did not make a credibility finding. We are not persuaded by claimant's line of reasoning. A Referee need not make a credibility assessment of all witnesses in each and every case to avoid remand. Not all witnesses lend themselves to either a positive or negative credibility finding. Accordingly, we are not persuaded that the record in this case was improperly, incompletely or otherwise insufficiently developed. Remand is, therefore, not appropriate.

Medical Services

The Referee upheld the the insurer's medical services denial on the basis that continued medical treatment was not "reasonably necessary." See James v. Kemper Insurance Co., 81 Or App 80, 84 (1986). We agree.

The insurer's denial was based both on the contention that claimant's current condition was no longer causally related to the April, 1986, compensable injury, and that the current treatment was not reasonable and necessary treatment. Therefore, claimant must prove both that the April, 1986, compensable injury remains a material contributing cause of his current back condition, see ORS 656.245(1); Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987), and that his current treatment is reasonable and necessary. We conclude that he has proven that his current condition is causally related to the compensable injury, but has failed to prove that his current treatments are reasonable and necessary.

Claimant was examined by the Western Medical Consultants in May, 1987. The Consultants found him medically stationary with no objective permanent impairment. In August, 1987, Dr. Duncan, a chiropractor, examined claimant and diagnosed a fully resolved lumbosacral strain without permanent impairment. The following month, Dr. Bald, claimant's treating orthopedist, "completely" concurred with Duncan. In December, 1987, Dr. Bardana, M.D., examined claimant and found an "entirely" resolved lumbosacral strain. Claimant testified that he has never been free of back pain since the April, 1986, injury.

We are persuaded that claimant's current condition, diagnosed as a resolved lumbosacral strain, is still materially caused by the compensable injury. No physician states that claimant's subjective complaints are not related to the compensable injury. Their comments are directed to amount of impairment rather than to causation.

However, we conclude that claimant's current treatments are not reasonable and necessary treatment for the compensable injury. We adopt the Referee's conclusions on this issue.

Jurisdictional

At the beginning of the hearing, the insurer's counsel raised the following affirmative defense:

> "With respect to the issue of disability question, it's [the employer's] position that there is no Determination Order, and that the Hearings Division doesn't have jurisdiction to reach that issue, and the reason is, even though we have something that's captioned Determination Order, what it did was set aside another Determination Order and basically leaves intact the Notice of Closure. I think it's significant in this case that the Notice of Closure is more than a year old and, therefore, there really isn't even any jurisdiction for the department to touch that."

The Referee agreed with the insurer's jurisdictional argument and, therefore, declined to reach the merits of the extent of disability issue. We disagree.

Claimant's April, 1986, back injury was initially closed by a Notice of Closure, dated August 19, 1986. Subsequently, the Evaluation Division issued two Determination Orders; the first, dated November 2, 1987, and the second, dated December 16, 1987. The December, 1987, Determination Order withdrew the November, 1987, Determination Order "in its entirety" and "reinstated" the August, 1986, Notice of Closure. After the issuance of the December, 1987, Determination Order, claimant timely requested a hearing raising the issue of the extent of his unscheduled permanent disability.

The Hearings Division has jurisdiction over "any question concerning a claim." ORS 656.283(1). The issue of a worker's extent of unscheduled permanent disability due to a compensable injury, see ORS 656.214(5), is plainly a "question concerning a claim." Here, a valid Determination Order issued in December, 1987, which, inter alia, declined to award permanent unscheduled disability for claimant's back condition. Claimant timely contested that Determination Order by requesting a hearing well within one year of its issuance. See former ORS 656.268(6). Accordingly, the Hearings Division had "jurisdiction" to hear the extent of disability issue.

The insurer raised the affirmative defense of timeliness. Specifically, the insurer argued that claimant did not request the Evaluation Division to issue a Determination Order

within one year of the date of the Notice of Closure, see former ORS 656.268(3). It is the insurer's burden, not claimant's, to prove an affirmative defense to an issue properly raised by claimant. As we found above, the issue of extent of disability was properly before the Hearings Division. The insurer has presented no evidence, other than mere conjecture, that claimant did not timely request the Evaluation Division to issue a Determination Order. The fact that the Evaluation Division failed to issue a Determination Order within the mandatory one-year period of former ORS 656.268(3), does not establish that claimant failed to timely request the issuance of a Determination Order. See Clifford L. Haines, 39 Van Natta 427 (1987). Under such circumstances, we conclude that the insurer has not proven its affirmative defense.

Extent of Disability

In rating the extent of unscheduled permanent disability for claimant's back condition, we consider his physical impairment as reflected in the medical record and the testimony at hearing and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Here, the consensus of the medical experts, including the treating orthopedist, Dr. Bald, is that claimant's back strain has fully resolved with no permanent physical impairment. Although claimant complains of continuing pain, when compared with the medical evidence, we do not consider these complaints to be disabling.

In sum, we are not persuaded that claimant has a permanent loss of earning capacity due to the April, 1986, compensable injury.

ORDER

The Referee's order is affirmed in part and reversed in part. That portion of the Referee's order that declined to address the issue of the extent of claimant's unscheduled permanent disability for his back condition is reversed. However, claimant is entitled to no award for permanent disability. That portion of the Referee's order which upheld the insurer's denial is reversed in part and affirmed in part. That portion of the denial which denied causation is set aside; the balance of the denial is upheld. All remaining portions of the Referee's order are affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,080.

JAMES M. McNAUGHT, Claimant	WCB 87-15977
Doblie & Associates, Claimant's Attorneys	November 15, 1989
Noreen K. Saltveit, Defense Attorney	Order on Review

Claimant requests review of Referee Norr's order that: (1) affirmed a Determination Order which awarded no permanent disability; and (2) upheld the insurer's oral partial denial, at hearing, of claimant's psychological condition claim. On review, claimant objects to the Referee's denial of his request for a continuance of the hearing to appeal the denial and prepare for the denial issue. We remand.

FINDINGS OF FACT

Claimant was compensably injured in June 1986. Claimant was diagnosed as having a thoraco-lumbar strain/sprain and he remained off work until September 1986. Following a period of part-time work, claimant was released to full-time work in December 1986.

Claimant was terminated from work in April 1987, for reasons unrelated to his compensable injury. In September 1987, claimant was found to be medically stationary with no loss of function or measurable impairment as a consequence of the work related injury. A Determination Order was issued on October 8, 1987, which did not award permanent disability. Claimant requested a hearing.

At the hearing, claimant sought entitlement to permanent disability. In addition, claimant, for the first time, contended that he had suffered psychological impairment arising from the compensable injury. In response, the insurer elected to orally deny the claim for psychological benefits.

The Referee offered a continuance to the insurer, but it rejected the offer. Claimant, however, requested a continuance. Since the claim had just been denied, claimant reasoned that he was entitled to a 60-day period following the denial, in which to file a hearing request.

CONCLUSIONS OF LAW AND OPINION

The Referee denied claimant's request for a continuance. The Referee reasoned that claimant had waited to raise an issue at a late date and was unable to show that the issue could not have been previously raised with due diligence.

Claimant contends that the Referee improperly denied his request for a continuance, since ORS 656.262(8) provides that upon a denial of a claim, claimant is entitled to a 60-day period in which he may file a hearing request. We agree.

The insurer treated the claim as one for a psychological condition as opposed to a request for permanent partial disability due to a psychological impairment arising from the work-related injury. Since the insurer chose to deny the psychological condition, claimant was entitled to a 60-day period in which to request a hearing concerning the denial. See Syphers v. K-W Logging, Inc., 51 Or App 769, 771 rev den 291 Or 151 (1981).

Pursuant to ORS 656.295(5), we may remand to the Referee for further evidence taking, correction or other necessary action when we determine that a case has been improperly, incompletely, or otherwise insufficiently developed or heard by a Referee. Under these circumstances, we conclude that remand is appropriate on the issue of compensability.

The Referee who initially heard this case is no longer employed by the Hearings Division. Accordingly, this matter is remanded to the Assistant Presiding Referee for the Portland office with instructions to refer this matter to another Referee. That Referee is instructed to schedule a hearing, at which time evidence shall be taken concerning only the merits of the insurer's denial of claimant's psychological condition. No

additional evidence regarding the extent of disability issue shall be taken. Following the closing of the record, the Referee shall proceed to address the compensability and extent of disability issues and any other issues that logically flow from these issues.

ORDER

The Referee's order dated February 25, 1988, is vacated. This matter is remanded to the Assistant Presiding Referee for the Portland office for further proceedings consistent with this order.

LESLIE G. MULLENIX, Claimant — WCB 87-10665
Bischoff & Strooband, Claimant's Attorneys — November 15, 1989
Brian L. Pocock, Defense Attorney — Corrected Order on Review

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of those portions of Referee Nichols' order that: (1) set aside its aggravation denial of claimant's back condition; and (2) alternatively, set aside its denial of current medical services for the same condition. On review, the issues are aggravation and medical services. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional finding. Claimant's compensable 1983 back injury is a material contributing cause of his current back condition and need for chiropractic treatment.

CONCLUSIONS OF LAW

We adopt the Referee's conclusions concerning the medical services issue with the following supplementation concerning the aggravation issue.

In concluding that claimant had proven an aggravation, the Referee found that: "The record does not show when the claim was closed." Although we agree with the Referee that the aggravational denial should be set aside, we do so for different reasons.

To establish an aggravation, claimant must prove, a worsening since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). Here, we have searched the record in vain. After doing so, we find no exhibit or testimonial reference to the date of the last arrangement of compensation.

However, the Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2) (ORE 201(b)). To date, our authority to take administrative notice has been limited to orders of the Board or of a Referee, or to stipulations by the parties. Groshong v. Montgomery Ward, 73 Or App 403 (1985). In Susan Teeters, 40 Van Natta 115 (1988), the Board noted in dicta that it "may" be able to take administrative notice of a Request for Hearing. 40 Van Natta at 1118. Finding, however, that the Request for Hearing that was at issue was "not present in any file of the

Workers' Compensation Board[,]" the Board declined in Susan Teeters to exercise its authority to take administrative notice. 40 Van Natta at 1119.

Here, another file of the Workers' Compensation Board contains a February 22, 1989, Determination Order, which closed claimant's 1983 back injury claim. WCB Case No. 89-04230. Inasmuch as that Determination Order indicates that claimant has five years from February 22, 1989, to file an aggravation claim, we deduce that it necessarily was the first closure of the 1983 back claim. See ORS 656.273(4)(a). In other words, claimant's claim was not closed until February 22, 1989, well after the date in which the record presently before us in WCB Case No. 87-10665 was closed.

Pursuant to Groshong, supra, and Susan Teeters, supra, we conclude that we may take administrative notice of a Determination Order in one of our files. After doing so, we conclude that at the time this case was litigated, claimant's 1983 back claim remained open. Inasmuch as there was no last arrangement of compensation at that time, the aggravation issue is nonexistent.

In sum, after taking administrative notice, we conclude that the employer's aggravation denial is a nullity. Consequently, the denial should be set aside as null and void.

Claimant's attorney is entitled to an assessed fee for services on Board review. However, inasmuch as we have not received, to date, a statement of services from claimant's attorney, we are unable to award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order, dated April 5, 1988, is affirmed. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $2,272.50.

DAVE G. OWEN, Claimant
CHARLES W. and MINERVA A. BLAIN, dba, Wesco Trucking, Employer
Kenneth D. Peterson, Claimant's Attorney
Leeroy Ehlers, Attorney
DebraAnn Kronenberg (SAIF), Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 86-09303
November 15, 1989
Order on Review

Reviewed by Board Members Nichols and Brittingham.

The alleged noncomplying employer, Charles W. & Minerva A. Blain, dba Wesco Trucking, requests review of those portions of Referee Wasley's order that: (1) affirmed the Department's proposed order finding it to be a noncomplying employer; and (2) held that the Hearings Division lacked jurisdiction to consider the alleged employer's objections to the SAIF Corporation's acceptance of claimant's injury claim. Claimant cross-requests review of that portion of the Referee's order that awarded claimant's attorney a carrier-paid fee of $704.

On review the issues are subjectivity, jurisdiction, and attorney fees. We affirm the order of the Referee in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact as set forth in the "Findings of Fact and Conclusions" section of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

On the question of subjectivity, we adopt the findings and conclusions of the Referee. Claimant is a subject worker and Charles W. and Minerva A. Blain, dba Wesco Trucking, are subject employers.

Concerning the question of the employer's objections to SAIF's acceptance of claimant's injury claim, we agree with the Referee's ultimate conclusion, but not his rationale. The employers had properly requested a hearing on the question of whether they were subject employers and claimant was a subject employee. This request for hearing was received by the Board on July 7, 1986. On July 9, 1986, SAIF sent the employers a notice of acceptance of the claim. The employers were advised of their right to request a hearing if they objected to SAIF's acceptance. The employers failed to request a hearing regarding the notice of acceptance.

The responsibility of a noncomplying employer, served with a notice of claim acceptance, is limited to that of requesting a hearing on the matter of the claim acceptance. See Clark v. Linn, 98 Or App 393 (1989). Here, the employer has failed to meet even this minimal requirement.

Even if the request for hearing received by the Board on July 7, 1986 is regarded as raising the issue of the compensability of claimant's injury, it was filed two days before the claim had been accepted and was therefore premature. Premature requests for hearing on the issue of whether a claim should be accepted are ineffective and void. See Barr v. EBI Companies, 88 Or App 132 (1987). There being no timely request for hearing, neither the Referee nor the Board may address the propriety of SAIF's acceptance of the claim. For this reason we find that the Referee lacked authority to address SAIF's July 9, 1986 acceptance of claimant's claim, as this matter was not properly before the Referee at the time of the hearing.

Finally, we modify the Referee's award of $704 to claimant's attorney as an attorney fee. After considering the factors listed in OAR 438-15-010(6), we find that $1100 is a more reasonable sum to be awarded for claimant's attorney's services at hearing.

ORDER

The Referee's order dated March 29, 1988 is affirmed in part and modified in part. In lieu of the Referee's attorney fee award, claimant's attorney is awarded $1100 for services at hearing to be paid by the SAIF Corporation on behalf of the noncomplying employer. The remainder of the Referee's order is affirmed.

DIANNA D. HILL, Claimant
Frank J. Susak, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-12811
November 16, 1989
Order of Dismissal

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of Referee Danner's order that: (1) found that claimant had established "good cause" for her failure to timely request a hearing from the insurer's denial of claimant's occupational disease claim for her neck condition; and (2) set aside the insurer's denial of the claim. On review, the issues are jurisdiction and compensability. We reverse.

FINDINGS OF FACT

We adopt the findings of fact contained in the Referee's order with the following supplementation. The insurer denied the claim on April 7, 1987. Claimant's request for a hearing concerning the denial was filed on August 18, 1987.

ULTIMATE FINDINGS OF FACT

Claimant requested a hearing concerning the insurer's denial more than 60 days after the denial issued. Claimant has not established good cause for failing to file her hearing request within 60 days from the date of the denial.

CONCLUSIONS OF LAW AND OPINION

A request for a hearing from a denied claim must be filed within 60 days after claimant is notified, unless good cause for failure to file within that time is shown. ORS 656.319(1). Claimant may be entitled to a hearing if the request is filed more than 60 days after notification of the denial if she files the request no later than 180 days after notification of the denial and can establish that there was good cause for not filing the request within 60 days. ORS 656.319(1)(b). "Good cause," as used in ORS 656.319(1)(b) means the same kind of circumstances that would justify the setting aside of a civil default judgement under ORCP 71(B) or former ORS 18.160. Brown v. EBI Companies, 289 Or 455, appeal after remand, 289 Or 905, (1980); Anderson v. Publishers Paper Co., 78 Or App 513, rev den 301 Or 666 (1986), appeal after remand, 93 Or App 516 (1986).

Here, claimant concedes that she failed to request a hearing within 60 days of the April 7, 1987 denial. However, claimant alleges, and the Referee found, that she had good cause for her failure to file a timely request because she relied upon her first treating physician's erroneous diagnosis of the cause of her back and neck pain stating that she had "mixed arthritis osteoarthritis" which had "not been worsened or caused by her employment." We disagree with the Referee's conclusion and reverse.

Anderson v. Publishers Paper Co., supra, is dispositive. In Anderson the claimant contended that he had good cause for his failure to make a timely request for a hearing because a physician told him that his condition was unrelated to his compensable injury. The court held that his reliance on the erroneous advice from the doctor was not good cause for his untimely appeal of his denial.

Here, as in Anderson, claimant was aware that her claim had been denied, that there were time limitations on the right to request a hearing, that she continued to have problems, and she suspected that her problems were work related. Nevertheless, she did not file a request for a hearing until well after the 60 day limitation. Her failure to file the timely request was not based upon "mistake, inadvertence, surprise or excusable neglect." ORCP 71B(1).

Consequently, claimant has not met her burden of proving that she had good cause for failing to file a timely request for a hearing from the April 7, 1987 denial. Accordingly, claimant's hearing request is dismissed as untimely.

Considering our decision concerning the jurisdictional issue, we do not reach the merits of the compensability issue.

ORDER

The Referee's order dated February 23, 1988 is reversed. Claimant's hearing request is dismissed. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $936.

GEORGE W. JORDAN, Claimant — WCB 87-10805
Malagon, et al., Claimant's Attorneys — November 16, 1989
Nancy Marque (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Paulus' order that upheld the SAIF Corporation's denial of his aggravation claim for a cervical condition. SAIF contends that claimant is precluded by application of res judicata principles from challenging the denial. We reject SAIF's res judicata argument but nevertheless affirm on the merits.

ISSUES

1. Res Judicata. Whether SAIF's unchallenged July 11, 1983 denial bars claimant from litigating the compensability of his current condition?

2. Compensability. If claimant's claim is not barred, then whether claimant has proven compensability of his claim?

FINDINGS OF FACT

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

SAIF's July 11, 1983 denial stated, in part:

> "We do not feel your current headaches and neck pain is a result of your September 3, 1982 incident. It would appear that it is a result of your underlying pre-existing degenerative disc condition of the cervical area or muscular contraction tension neither of which are related to your September 3, 1982 incident. Accordingly,

we will not assume responsibility for current treatment and/or time loss associated with same."

SAIF's August 17, 1987 denial stated, in part:

"There is lack of information of any evidence that you have sustained an aggravation to your accepted condition. Additionally, SAIF Corporation denied treatment for headache and neck pain by denial letter dated July 11, 1983, because it appeared your medical conditions were related to your underlying pre-existing degenerative disc condition.

"Therefore, without waiving further questions of compensability, we submit this denial of aggravation and of current medical treatment for your degenerative disc disease of the cervical spine."

CONCLUSIONS OF LAW AND OPINION

Res Judicata

SAIF contends that claimant's failure to challenge its July 11, 1983 denial bars claimant from litigating the merits of the August 17, 1987 aggravation denial. We disagree. In this regard, the res judicata effect of the August 1983 denial is limited to the conditions denied as they existed on or before the date of the denial. See David E. Gates, 40 Van Natta 798, 800 (1988). Even if claimant were precluded from arguing that his condition requiring treatment in July 1983 was related to his original injury, he could not be foreclosed from proving that his compensable condition worsened at a later time to the extent that it required treatment or resulted in additional disability. See Thomas A. Beasley, 37 Van Natta 1514, 1516 (1985).

Propriety of the August 17, 1987 Denial

The Referee concluded that claimant had not proven that the condition currently being treated was, in fact, related to his compensable injury. We adopt the Referee's "Conclusions" in this regard, with the following supplementation.

Dr. Goodwin reported in May 1983 that claimant's headaches dated back to at least 1972. Moreover, following a review of claimant's medical file, Dr. Reilly, neurologist, opined that claimant's headaches were unrelated to his compensable September 1982 injury. Given the unpersuasiveness of Dr. Gorman's opinion, as discussed by the Referee, as well as the contrary opinions of Drs. Goodwin and Reilly, we conclude that claimant has failed to sustain his burden of proof.

ORDER

The Referee's order dated February 19, 1988 is affirmed.

RAY H. LYONS, Claimant
Ormsbee & Corrigall, Claimant's Attorneys
Marcus Ward, Defense Attorney
Rankin, et al., Defense Attorneys
Dennis Ulsted (SAIF), Defense Attorney
Foss, et al., Defense Attorneys

WCB 87-16040, 87-16039, 87-14542
& 87-09757
November 16, 1989

Reviewed by Board Members Howell and Perry.

Argonaut Insurance Company (Argonaut) requests review of those portions of Referee Blevins' order that: (1) set aside its aggravation denial of claimant's low back condition; and (2) upheld the SAIF Corporation's "new injury" denial of the same condition. SAIF informally cross-requests review of that portion of the Referee's order that assessed a penalty-related attorney fee for its alleged unreasonable denial of compensability. We reverse in part and affirm in part.

ISSUES

1. Responsibility.

2. Penalty-related attorney fee.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on August 18, 1981 while employed as a log truck driver for Coos Trucking Company, insured by Argonaut. He injured himself while tightening binders on a log load. The injury resulted in a herniated disc at L5-S1. Surgical repair of this condition was undertaken on February 10, 1982, by Dr. Whitney, orthopedic surgeon. Claimant thereafter returned to work in the summer of 1982. His claim was closed by Determination Order dated December 9, 1982, which awarded 10 percent (32 degrees) unscheduled permanent disability.

In June 1982, SAIF replaced Argonaut as the workers' compensation carrier for Coos Trucking.

Claimant continued to work as a short-haul truck driver for Coos Trucking. His symptoms initially improved following surgery, although he continued to experience low back pain radiating to his right leg. However, after approximately one and one-half years, his symptoms began to progressively worsen so that, in March 1986, he returned to Dr. Whitney. Claimant again sought medical treatment from Dr. Whitney in June 1986.

Claimant was terminated by Coos Trucking in September 1986. His termination resulted from his failure to show up for work. This failure, in turn, resulted from the combination of his low back symptoms and an unrelated office dispute.

Following a January 1987 off-work incident, claimant experienced increased low back pain, as well as the onset of left leg symptoms. Subsequent testing disclosed a reherniation at the L5-S1 level. In April 1987, Dr. Whitney requested authorization to perform additional surgery to repair this problem.

On June 19, 1987, Argonaut issued a denial of claimant's condition on responsibility grounds. On September 17, 1987, SAIF issued a denial on grounds of compensability. SAIF's denial stated, in part:

we will not assume responsibility for current treatment and/or time loss associated with same."

SAIF's August 17, 1987 denial stated, in part:

"There is lack of information of any evidence that you have sustained an aggravation to your accepted condition. Additionally, SAIF Corporation denied treatment for headache and neck pain by denial letter dated July 11, 1983, because it appeared your medical conditions were related to your underlying pre-existing degenerative disc condition.

"Therefore, without waiving further questions of compensability, we submit this denial of aggravation and of current medical treatment for your degenerative disc disease of the cervical spine."

CONCLUSIONS OF LAW AND OPINION

Res Judicata

SAIF contends that claimant's failure to challenge its July 11, 1983 denial bars claimant from litigating the merits of the August 17, 1987 aggravation denial. We disagree. In this regard, the res judicata effect of the August 1983 denial is limited to the conditions denied as they existed on or before the date of the denial. See David E. Gates, 40 Van Natta 798, 800 (1988). Even if claimant were precluded from arguing that his condition requiring treatment in July 1983 was related to his original injury, he could not be foreclosed from proving that his compensable condition worsened at a later time to the extent that it required treatment or resulted in additional disability. See Thomas A. Beasley, 37 Van Natta 1514, 1516 (1985).

Propriety of the August 17, 1987 Denial

The Referee concluded that claimant had not proven that the condition currently being treated was, in fact, related to his compensable injury. We adopt the Referee's "Conclusions" in this regard, with the following supplementation.

Dr. Goodwin reported in May 1983 that claimant's headaches dated back to at least 1972. Moreover, following a review of claimant's medical file, Dr. Reilly, neurologist, opined that claimant's headaches were unrelated to his compensable September 1982 injury. Given the unpersuasiveness of Dr. Gorman's opinion, as discussed by the Referee, as well as the contrary opinions of Drs. Goodwin and Reilly, we conclude that claimant has failed to sustain his burden of proof.

ORDER

The Referee's order dated February 19, 1988 is affirmed.

RAY H. LYONS, Claimant
Ormsbee & Corrigall, Claimant's Attorneys
Marcus Ward, Defense Attorney
Rankin, et al., Defense Attorneys
Dennis Ulsted (SAIF), Defense Attorney
Foss, et al., Defense Attorneys

WCB 87-16040, 87-16039, 87-14542 & 87-09757
November 16, 1989

Reviewed by Board Members Howell and Perry.

Argonaut Insurance Company (Argonaut) requests review of those portions of Referee Blevins' order that: (1) set aside its aggravation denial of claimant's low back condition; and (2) upheld the SAIF Corporation's "new injury" denial of the same condition. SAIF informally cross-requests review of that portion of the Referee's order that assessed a penalty-related attorney fee for its alleged unreasonable denial of compensability. We reverse in part and affirm in part.

ISSUES

1. Responsibility.

2. Penalty-related attorney fee.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on August 18, 1981 while employed as a log truck driver for Coos Trucking Company, insured by Argonaut. He injured himself while tightening binders on a log load. The injury resulted in a herniated disc at L5-S1. Surgical repair of this condition was undertaken on February 10, 1982, by Dr. Whitney, orthopedic surgeon. Claimant thereafter returned to work in the summer of 1982. His claim was closed by Determination Order dated December 9, 1982, which awarded 10 percent (32 degrees) unscheduled permanent disability.

In June 1982, SAIF replaced Argonaut as the workers' compensation carrier for Coos Trucking.

Claimant continued to work as a short-haul truck driver for Coos Trucking. His symptoms initially improved following surgery, although he continued to experience low back pain radiating to his right leg. However, after approximately one and one-half years, his symptoms began to progressively worsen so that, in March 1986, he returned to Dr. Whitney. Claimant again sought medical treatment from Dr. Whitney in June 1986.

Claimant was terminated by Coos Trucking in September 1986. His termination resulted from his failure to show up for work. This failure, in turn, resulted from the combination of his low back symptoms and an unrelated office dispute.

Following a January 1987 off-work incident, claimant experienced increased low back pain, as well as the onset of left leg symptoms. Subsequent testing disclosed a reherniation at the L5-S1 level. In April 1987, Dr. Whitney requested authorization to perform additional surgery to repair this problem.

On June 19, 1987, Argonaut issued a denial of claimant's condition on responsibility grounds. On September 17, 1987, SAIF issued a denial on grounds of compensability. SAIF's denial stated, in part:

"We have carefully reviewed all information in your file and find that your employment at Coos Trucking Company is not the major contributing factor toward the development of back pain. Therefore, without waiving further questions of compensability, we must deny your claim."

SAIF subsequently resisted issuance of an ORS 656.307 order. No .307 order was issued.

Claimant purchased a sawmill for his home use during the winter of 1985/1986. The sawmill was not put to much use until August 1986. At that time, claimant's involvement required only minimal physical exertion. This exertion did not contribute to a worsening of his condition.

Claimant's work activities for the employer between 1982 and 1986 independently contributed to a worsening of his low back condition. In particular, those work activities resulted in increased degenerative processes in his low back which eventually resulted in a reherniated disc. This worsened condition required medical services.

SAIF's September 9, 1987 denial on compensability grounds was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee assigned responsibility for claimant's current condition to Argonaut as the insurer on the risk at the time of claimant's original 1981 injury and subsequent surgery. The Referee reasoned that claimant's need for treatment in 1986 and thereafter "was primarily due to the surgery that he underwent in February, 1982." We disagree.

This is a case involving a specific traumatic injury during the first employment followed by a gradual worsening, with no specific traumatic event, during the second employment. Under such circumstances the applicable standard is that expressed by the court in Hensel Phelps Const. Co. v. Mirich, 81 Or App 290 (1986). See also Home Insurance Co. v. EBI Cos., 76 Or App 112 (1985). Pursuant to Mirich, the determinative inquiry is whether the second period of employment independently contributed to a pathological worsening of the underlying condition. Id. at 294. If such a contribution did occur, and if disability or a need for medical services results from the worsening, then responsibility for claimant's current condition rests with the second employer/insurer.

Argonaut contends in this regard that the evidence overwhelmingly establishes that claimant's employment activities from 1982 through August 1986, while SAIF was on the risk, independently contributed to a worsening of his underlying condition. We agree. Dr. Whitney unequivocally testified in a post-hearing deposition that the ongoing stress of claimant's work activities between 1982 and 1986 contributed to further degeneration of his low back, eventually resulting in the L5-S1 reherniation. He similarly reported on November 17, 1987. Dr. Whitney was claimant's treating physician throughout this

period of time. Moreover, he performed the initial surgery on claimant. Accordingly, his opinion is entitled to considerable weight. See Weiland v. SAIF, 64 Or App 810 (1983).

In addition, claimant was examined by Dr. Baker, orthopedic surgeon, on August 12, 1987. Like Dr. Whitney, Dr. Baker was of the opinion that claimant's work activities between 1982 and 1986 had independently contributed to claimant's condition. Further, the record is devoid of any medical opinions to the contrary.

We conclude that claimant's work activities for while SAIF was on the risk independently contributed to a pathological worsening of his condition. This worsened condition forced claimant to seek Dr. Whitney's services. Moreover, Dr. Whitney has requested authorization to perform surgical procedures to address the worsened condition. Accordingly, responsibility for claimant's current condition rests with SAIF.

Penalty-Related Attorney Fee

The Referee assessed a penalty-related attorney fee against SAIF, finding that SAIF's compensability denial was unreasonable. SAIF argues on review that its denial cannot be found unreasonable merely because the evidence at hearing was insufficient to sustain the denial. We agree, in general, with SAIF's position. However, we are nevertheless unable to find that SAIF's denial was reasonable in light of the information available to it at the time of the denial.

SAIF's attorney stated at hearing that the denial was based upon SAIF's belief that claimant's worsened condition was attributable to his nonindustrial sawmill work. Counsel for SAIF further stated that evidence would be produced which would show that investigatory reports had uncovered this potential off-work cause of claimant's condition.

We first note that the denial itself makes no mention of any off-work activity having caused claimant's worsened condition. In addition, the record contains no evidence, documentary or testimonial, to support counsel's position that SAIF was, in fact, aware of claimant's sawmill activities at the time that it denied claimant's claim. In particular, the investigatory reports referred to by counsel were never offered or admitted to the record. In the absence of any such evidence, we are unable to find as fact that SAIF's denial was premised upon claimant's sawmill activities. Because no other grounds support a denial of compensability, as opposed to responsibility, we conclude that SAIF's denial was unreasonable. Moreover, as a result of SAIF's compensability denial, no .307 order issued pending hearing. Consequently, claimant was left without benefits pending issuance of the Referee's order. Therefore, the Referee's assessment of a penalty-related attorney fee was proper.

Claimant's counsel has submitted a statement of services in connection with his representation of claimant on Board review. Counsel's appearance on Board review was expressly limited to the penalty-related attorney fee issue. Inasmuch as attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to attorney fees for successfully defending such an award on review. See Sexton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated March 3, 1988 is affirmed in part and reversed in part. The denial issued by Argonaut Insurance Company dated June 19, 1987 is reinstated and upheld. The denial issued by the SAIF Corporation dated September 17, 1987 is set aside and the claim is remanded to SAIF for acceptance and processing according to law. SAIF, rather than Argonaut, shall be responsible for payment of the $1,500 assessed fee awarded to claimant at hearing. The Board approves a client-paid fee, not to exceed $1,244, payable by Argonaut to its counsel. The Board approves a client-paid fee, not to exceed $135, payable by SAIF to its outside counsel appearing on behalf of James K. Hill Trucking. The Board approves a client-paid fee, not to exceed $210, payable by SAIF to its outside counsel appearing on behalf of G & C Logging Company. The remainder of the Referee's order is affirmed.

FRANK McLEAN, Claimant
Black, et al., Claimant's Attorneys
Arthur Stevens (SAIF), Defense Attorney

WCB 86-10718
November 16, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Livesley's order that: (1) declined to grant permanent total disability; and (2) awarded an additional 40 percent (128 degrees) unscheduled permanent disability for neck and back conditions, beyond a Determination Order that had awarded 30 percent (96 degrees), for a total unscheduled award of 70 percent (224 degrees).

The Board affirms in part and modifies in part the order of the Referee.

ISSUES

1. Whether claimant is permanently and totally disabled.

2. Alternatively, the extent of claimant's unscheduled permanent disability for his neck and back conditions.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Drs. Dunn and Kho agree that claimant cannot return to work as a tree-faller. Claimant's limitations are as follows: No lifting beyond 10 pounds, no bending or twisting, and no prolonged sitting, standing, or walking. Given claimant's limitations, we find that he has moderate permanent physical impairment and that he is presently limited to performing work within sedentary occupations.

CONCLUSIONS OF LAW

Permanent Total Disability

The Board adopts that portion of the Referee's opinion pertaining to the issue of permanent total disability.

Unscheduled Permanent Disability

In rating the extent of unscheduled permanent disability for claimant's neck and back conditions, we consider his physical impairment as reflected in the medical record, the lay testimony at the hearing, and all of the relevant social and vocational factors set forth in former OAR 436-30-380, et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance, 296 Or 505 (1984).

The Referee found that claimant was entitled to an award of unscheduled permanent disability in excess of the 30 percent granted by the Determination Order. We agree, but modify the Referee's order to reflect a greater total award than 70 percent unscheduled permanent disability.

Claimant is 61 years old. He has virtually no work experience or training outside of 38 years of heavy labor within the logging industry. He has moderate permanent physical impairment, as a result of his compensable neck and back conditions. He cannot lift in excess of 10 pounds nor engage in prolonged sitting, standing, or walking. His ability to operate a motor vehicle is also significantly restricted.

The medical experts agree that claimant is permanently precluded from returning to heavy work within the logging industry. Moreover, we have found above that claimant is limited to sedentary occupations. The vocational experts agree that claimant is presently unemployable. See Gettman v. SAIF, 289 Or 609 (1980) (A worker's permanent disability must be evaluated as it exists at the time of the hearing). Vocational counselor Hutson opined that with retraining, claimant could probably perform work as a saw filer. Tr. 57-9; Ex. 54-18. Presently, however, claimant has no transferable skills to obtain direct employment in a sedentary occupation. Id.

Given claimant's age, moderate permanent physical impairment, entirely heavy work experience, and complete lack of transferable skills to sedentary occupations, we conclude that an award of 100 percent permanent disability appropriately compensates him for his loss of earning capacity due to the compensable injury of October, 1984.

ORDER

The Referee's order, dated March 10, 1988, is affirmed in part and modified in part. In liew of the Referee's award of unscheduled permanent disability and in addition to the 30 percent (96 degrees) Determination Order award, claimant is granted an additional award of 70 percent (224 degrees), for a total award of 100 percent (320 degrees) unscheduled permanent disability. Claimant's attorney is awarded an approved fee equal to 25 percent of the increased compensation awarded by this order, provided that the total of fees approved by the Referee and the Board does not exceed $3,800. The remainder of the Referee's order is affirmed.

THOMAS J. REID, Claimant
Peter O. Hansen, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 88-02815
November 16, 1989
Order of Dismissal

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of that portion of Referee Knapp's order which awarded claimant's attorney a reasonable carrier-paid fee of $800 for his services rendered in evoking the recission of the self-insured employer's denial of claimant's medical services claim prior to hearing. The sole issue on review is the amount of the attorney fee awarded. Under such circumstances, we have no jurisdiction to review the attorney fee. Arbra Williams, 40 Van Natta 506 (1988). The proper forum for review of this attorney fee is the circuit court pursuant to the provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, 305 Or 530, 534 (1988).

Accordingly, the request for review is dismissed and the order of the Referee is final by operation of law. A client-paid fee, payable from the self-insured employer to its counsel, not to exceed $346, is approved.

IT IS SO ORDERED.

BILLY J. RUCKER, Claimant
Vick & Gutzler, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 87-06001 & 86-16402
November 16, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Knapp's order which: (1) upheld Western Foundry's denial of claimant's aggravation claim for a low back injury; and (2) upheld the SAIF Corporation's "new injury" denial of the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant first sustained a compensable low back injury in 1975 while working for Western Foundry. Claimant sustained a second compensable back strain in 1981.

In February 1982, claimant again experienced low back pain, as well as left buttock and left leg pain. Western Foundry was self-insured at that time. Claimant was treated by Dr. Struckman, who diagnosed chronic disc herniation and degenerative disc disease. A CT scan was positive for an L5-S1 disc herniation and degenerative change, but a myelogram was negative. Surgery was considered, but not recommended after a period of conservative care. A claim for claimant's back condition at that time was accepted by Western Foundry.

In September 1982, Dr. Struckman declared claimant medically stationary with moderate back impairment. He recommended vocational training with limitations on repetitive bending and lifting over 40 pounds. Claimant was referred to the Callahan Center for assessment. The evaluators at the Callahan Center concluded that he would be capable of engaging in light duty work. A closing exam was performed by the Orthopaedic

Consultants in January 1983. The Consultants concluded that claimant's condition was a result of the 1982 compensable injury and his degenerative joint diseases.

Claimant was engaged in vocational training in 1983 and early 1984. In March 1984, Dr. Struckman examined claimant and indicated that claimant had no leg pain, no significant back pain but had an aching sensation in his left buttock. Claimant had no radicular symptoms. Dr. Struckman reported that claimant had mildly moderate disability and recommended that he should not perform work that required repetitive bending, prolonged standing or walking or lifting over 20 pounds. Claimant's claim was closed by an April 1984 Determination Order, which awarded 25 percent unscheduled permanent disability. This award was increased by stipulation to 40 percent.

In March 1985, claimant began working at a gas station which was insured by SAIF. His primary duty was to pump gas. He continued that job for over a year. He had continuing left buttock pain, particularly when standing. However, he sought no medical treatment because he understood nothing could be done for him. In early 1986 claimant's pain increased. By late June 1986 claimant's pain had increased to the point that he could not lift his leg and had to drag it when he walked. He laid on a desk in the service station to attempt to relieve his pain. He worked part-time, two days a week, ten hours per day.

On June 30, 1986, claimant sought treatment from Dr. Stellflug, chiropractor, for complaints of low back and left leg pain. Dr. Stellflug diagnosed "IVD" syndrome and lumbar strain complicated by structural deficit and myofascitis. He took claimant off work at that time. Dr. Stellflug referred claimant for an MRI scan which showed paracentral disc bulge at L5-S1 and a possible L5-S1 forminal encroachment.

In October 1986, Western Foundry denied claimant's aggravation claim on the basis that his condition had not materially worsened. In May 1987, SAIF denied responsibility for claimant's low back condition on the basis that his employment with its insured did not independently contribute to his disability.

In January 1987, Dr. Stellflug reported that claimant's condition was medically stationary, but that further palliative care was indicated.

FINDINGS OF ULTIMATE FACT

Claimant's current low back condition is causally related to his 1982 compensable injury.

Due to his 1982 compensable injury, claimant was unable to work on June 30, 1986 and for several months thereafter.

CONCLUSIONS OF LAW

The Referee concluded that claimant had sustained neither an aggravation of his 1982 compensable injury, nor a "new injury" while at SAIF's insured. We disagree.

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact

must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987). Further, claimant carries the burden of proving that a condition giving rise to a need for medical treatment or disability is materially related to a compensable claim. Grable v. Weyerhaeuser Co., 291 Or 397 (1981); Milburn v. Weyerhaeuser Co., 88 Or App 375 (1987).

Western Foundry conceded at hearing that claimant's condition after June 1986 was materially related to his 1982 injury. It denied only that he was entitled to additional benefits under ORS 656.273 for a worsened condition. Claimant's condition is, therefore, compensable.

There is no persuasive evidence in this record that claimant's work with SAIF's insured independently contributed to a worsening of his underlying injury condition. There is, therefore, no basis for holding SAIF responsible for claimant's condition.

The only issue seriously argued on appeal is whether claimant proved a worsening of his injury condition after the last arrangement of compensation, an August 27, 1984 stipulation. We are persuaded that he did.

Unlike the test for shifting responsibility, claimant need not show a worsening of his underlying condition to prove aggravation. An increase in symptoms may represent an aggravation. Consolidated Freightways v. Foushee, 79 Or App 509 (1986)

We are persuaded by claimant's unrebutted testimony and Dr. Stellflug's opinion that in June 1986, and for some period thereafter, claimant's condition was worse than at the time of the last arrangement of compensation. That same evidence indicates that claimant's earning capacity was at least temporarily reduced by the worsening. See Smith v. SAIF, 302 Or 396 (1986). Dr. Struckman, who treated claimant up to near the time of the August 1986 stipulation, agreed that claimant's condition was temporarily worse in June of 1986.

At the time of the last arrangement of compensation in this matter claimant was expected to be able to perform light work. He did so in a service station for approximately 13 months before his condition worsened to the point that he could not lift his left leg or continue to work even two days per week. While some waxing and waning of claimant's condition may have been anticipated at the time of the August 1984 stipulation, there is no evidence suggesting that a worsening such as claimant experienced in June 1986 was anticipated. Accordingly, we conclude that claimant has established a compensable aggravation claim.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at the hearing and on Board review, concerning Western Foundry's aggravation denial. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated September 18, 1987 is reversed in part and affirmed in part. Western Foundry's denial is set aside and the claim is remanded to it for processing according to law. The remainder of the order is affirmed.

GARY W. ATWOOD, Claimant
Olson, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-11421
November 17, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of that portion of Referee St. Martin's order which granted claimant permanent total disability, whereas a Determination Order had awarded 30 percent (96 degrees) unscheduled permanent disability. Claimant cross-requests review of those portions of the Referee's order that: (1) upheld partial denials of claimant's vision and chest wall problems; and (2) declined to award a carrier-paid attorney fee for claimant's successful defense to the employer's contention that the Determination Order award be reduced. The issues on review are extent of disability, compensability, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact as contained in the "Findings" section of the order with the following exceptions and supplementation.

Claimant's dizziness was not caused by fistulas. Claimant's injury did not result in permanent inner ear damage.

Claimant's blurred vision and photophobia were not caused by his compensable head injury.

Claimant's work history is limited to medium to heavy labor in the lumber industry. He has no transferable skills and is functionally illiterate.

If claimant completes an authorized training program, it is possible that he could return to regular gainful and suitable employment. However, at the time of hearing, despite claimant's cooperation, no such program had been implemented.

CONCLUSIONS OF LAW AND OPINION

Extent of Disability

The Referee found claimant to be permanently and totally disabled. We agree with the Referee, but not for the reasons stated.

The Referee found the testimony of Dr. Black, that claimant's dizziness and vertigo problem was due to fistulas, to be most persuasive. We disagree. The overwhelming consensus of several other otolaryngologists and neurologists is that claimant's dizziness and vertigo were not due to significant inner ear injury and that there were no fistulas present. We therefore discount Dr. Black's opinions. However, that conclusion does not preclude a finding of permanent total disability.

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market." Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders work search futile, SAIF v. Scholl, 92 Or App 594, 597 (1988), he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

Claimant's low education level, his lack of transferable skills, and his restrictions against performing heavy physical labor combine to severely limit the types of jobs that he is capable of performing.

Nonetheless, at the time of hearing, based on the medical and vocational evidence, claimant was only capable of working after completion of an authorized training program. Whatever claimant's employability prospects might be after retraining, they cannot be considered in assessing his present level of disability. Gettman v. SAIF, 289 Or 609 (1980). At the time of hearing, an authorized training program was being arranged. However, that program had not yet been implemented.

A claimant who seeks benefits for permanent total disability must establish that he is willing to seek regular gainful employment and has made reasonable efforts to do so. ORS 656.206(3). We conclude that claimant has made reasonable efforts in seeking work. He has been cooperative by agreeing to participate in the authorized training program, and was willing to move to a new location in order to complete it.

Based on claimant's condition at the time of hearing, and not considering the question of employability after completion of an authorized training program, we conclude that he was entitled to permanent total disability for his compensable head injury.

Compensability

An injured worker is entitled to all reasonable and necessary medical services for a compensable injury. ORS 656.245. In order to prove compensability of medical services, the compensable injury need not be the sole cause, or the most significant cause of the need for treatment, but only a material cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Claimant contends that his vision problems and photophobia are a result of his compensable injury. The record contains conflicting reports from the ophthalmologist, Dr. Johnson, concerning the vision problems. Initially, he stated that they were not related to the injury, then he said they were. The Referee was not persuaded by this evidence and found the vision problems not related to the injury and, thus, not compensable.

Similarly, the Referee did not find any evidence that claimant's chest problems were related to the blow to the head, and found them not compensable. We agree with the Referee's assessment that claimant failed to establish the requisite causal relationship between his compensable injury and the above-mentioned problems.

Attorney Fees

The Referee declined to award a carrier-paid attorney fee. He reasoned that, since claimant had initiated the request for hearing, the only recourse for attorney fees was the increased compensation. Claimant argues that he is entitled to a carrier-paid attorney fee because he successfully defended against the employer's cross-request for hearing. We agree.

Claimant successfully defended against the employer's cross-request to reduce the award of the Determination Order and, thus, is entitled to reasonable attorney fees under ORS 656.382(2). Kordon v. Mercer Industries, 94 Or App 582, aff'd 308 Or 290 (1989).

When considering a reasonable attorney fee, we consider several factors including, time devoted to the case, complexity of issues involved, skill of the attorney, benefit secured for the claimant and risk that an attorney's efforts may go uncompensated. OAR 438-15-010(6). After considering these factors, we conclude that a reasonable attorney fee for claimant's counsel's services at hearing concerning the employer's cross-request is $750. This attorney fee is in addition to, not in lieu of, the $3000 extraordinary fee awarded by the Referee, payable out of claimant's permanent total disability award.

ORDER

The Referee's order dated November 5, 1987 is affirmed in part and reversed in part. For services at hearing in successfully defending the employer's contention that the Determination Order award be reduced, claimant's attorney is awarded a reasonable attorney fee of $750, to be paid by the employer. The remainder of the order is affirmed. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $3282.50. For successfully defending the award of permanent total disability on Board review, claimant's attorney is awarded a reasonable attorney fee of $1200, to be paid by the self-insured employer.

LENNE BUTCHER, Claimant
H. Philip Eder, Claimant's Attorney

Own Motion 89-0424M
November 17, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his March 17, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for proposed pain center treatment and recommends that claimant's claim be reopened for the payment of temporary disability benefits.

Under ORS 656.278(1)(a), we may exercise our "Own Motion" authority and reopen a claim for temporary disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment

requiring hospitalization. Accordingly, the Board has the authority to reopen a claim for pain center treatment requiring inpatient hospitalization. We can also reopen a claim for pain center treatment on an outpatient basis where overnight accommodation away from home is necessary to obtain maximum benefit from the treatment. Under these circumstances, pain center treatment is treated as hospitalization.

Here, the parties have not demonstrated that the proposed pain center treatment satisfies these criteria. As a result, we are not authorized to grant claimant's request for reopening. Accordingly, the request for own motion relief is denied.

IT IS SO ORDERED.

MARY E. WILLIAMS, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 89-0499M
November 17, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her February 20, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF Corporation has accepted responsibility for the claimant's condition and recommends that her claim be reopened for payment of temporary total disability benefits.

Under ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Accordingly, the Board has the authority to reopen a claim for pain center treatment requiring inpatient hospitalization. We can also reopen a claim for pain center treatment on an outpatient basis where overnight accommodation away from home is necessary to obtain maximum benefit from the treatment. Under these circumstances, pain center treatment is treated as hospitalization.

Here, the parties have not demonstrated that the proposed pain center treatment satisfies this criteria. As a result, we are not authorized to grant claimant's request for reopening. Accordingly, the request for own motion relief is denied.

IT IS SO ORDERED.

MARY A. WASHBURN, Claimant
Francesconi, et al., Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney

WCB 87-00629
November 17, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

The SAIF Corporation requests review of Referee G. Peterson's order that set aside its denial of claimant's right hand condition.

The Board reverses the order of the Referee.

ISSUE

Whether claimant sustained a compensable occupational disease in her right hand.

FINDINGS OF FACT

Claimant, 34 at hearing, noticed the gradual onset of right hand pain in September, 1986, while working as a part-time food service worker and cashier. During that month, her operation of the cash register increased from one-to-two hours a day. Her work at the cash register required fast, repetitive, and continuous use of her right hand. During her non-work hours she regularly performed routine domestic chores such as dishwashing, laundry, and gardening. Such activities required the repetitive use of her hands.

On September 30, 1986, claimant was examined by Dr. Koehler, M.D. Koehler diagnosed tendinitis, treated with anti-inflammatory medications, and took claimant off work for a few weeks. Claimant's right hand pain did not subside. On October 28, 1986, she sought treatment from Dr. Hurtado, M.D. Hurtado continued treating with anti-inflammatory medications and apparently released claimant to modified work, with limited use of her right hand. Dr. Button, a hand specialist, examined claimant on December 31, 1986. Button found no evidence of tendinitis and recommended that claimant return to regular work, while discontinuing further anti-inflammatory medications.

Claimant unsuccessfully attempted to return to unrestricted work during the early months of 1987. By July, 1987, however, she had returned to regular work and Dr. Hurtado had declared her medically stationary.

During September, 1986, claimant's right hand pain was the most severe during her two-hour cash register shifts. In the evening, her pain subsided.

CONCLUSIONS OF LAW

In finding that claimant's right hand condition was compensable, the Referee assigned greater weight to the opinions of Drs. Koehler and Hurtado, than to that of Dr. Button. We disagree.

To establish a compensable occupational disease, claimant must prove that her work activities were the major contributing cause of her right hand condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). If claimant's condition preexisted her employment, she must also prove that her work activities caused a worsening of her condition. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979).

In our view, the causation of claimant's right hand condition presents a complex medical question. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). First, there was no identifiable work incident or injury; claimant experienced an onset of right hand pain. Second, after three weeks of anti-inflammatory medication and a cessation of her work activities, claimant presented to Dr. Hurtado with "a marked increase of the pain" in her right hand. Last, independent of her work activities, claimant was regularly performing daily at-home domestic chores that required the repetitive use of her hands.

Although claimant's testimony is probative, it only establishes a temporal relationship between her right hand pain

and her increased cashiering duties. We are reluctant to infer causation from chronological sequence. Allie v. SAIF, 79 Or App 284 (1986); Edwards v. SAIF, 30 Or App 21, rev den 279 Or 301 (1977). Accordingly, we conclude that the resolution of this case largely turns on the medical evidence.

The opinion of Dr. Koehler consists of several pages of handwritten notes, parts of which are not legible. What is legible, is that on October 15, 1986, Koehler noted: "Could be related to repetitious work at cash register." (Emphasis added). On October 27, 1986, Koehler reexamined claimant and further noted: "Prob[ably] aggravated by running cash register." He concluded his chart note by diagnosing "tendinitis."

We are not persuaded by Koehler's opinion. First, he initially did not state his opinion with the requisite degree of medical probability. Second, after doing so, he speaks of an "aggravat[ion]." With no further elaboration by Koehler, we can do nothing more than speculate as to what he meant by use of the word "aggravat[ion]." Did Koehler mean that claimant had a pre existing condition? If so, we find nothing in the record to support such a finding. Claimant neither experienced right hand pain nor sought medical treatment related to her right hand until September, 1986; i.e., over two years after she began working for SAIF's insured. Moreover, it is not clear whether Koehler distinguished between an actual worsening of any alleged pre existing condition, and a mere symptomatic flare-up. See Wheeler and Weller, supra. Last, we find that Koehler's opinion is conclusory and lacks virtually any medical analysis. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

As to Dr. Hurtado he eventually diagnosed claimant's condition as "tenosynovitis" and opined that her condition was work related. We are not persuaded by Hurtado's opinion. First, Hurtado has changed his opinion several times. He initially reported that claimant's condition was probably related to work. On a subsequent form, he checked a box indicating that it was "undetermined" whether claimant's condition was the result of an industrial exposure or injury. Ex. 10. Next he concurred with the unequivocal opinion of Dr. Button that claimant's right hand condition was not work related. Exs. 12-2 & 16. Several months later, Hurtado began to change his opinion stating:

> "The exact cause of tenosynovitis is not clear; however, it is quite likely that this is produced by her work which requires constant rotation of her wrist and hand, and may very well have been the etiologic cause." (Emphasis added).

We have reservations about finding that the above-quoted opinion of Hurtado is stated in terms of a reasonable medical probability. Last, contrary to the finding of the Referee, Hurtado never stated that claimant's work activities were "the major contributing cause" of her right hand condition. O & O at 2. Rather, in October, 1987, Hurtado stated:

> "The condition for which I treated [claimant] was a tenosynovitis. In regard to your [claimant's attorney] specific question as to whether [claimant's] work was a [sic] major contributing factor in

her need for treatment for carpal tunnel syndrome, I do feel that the work was a contributing factor in the production and continuation of her condition." (Emphasis added).

Likewise, in December, 1987, Hurtado opined:

> "You posed a question to me regarding [claimant's] tenosynovitis, as to whether there were any other activities or off the job exposure during the period when the tenosynovitis came on which was significant as the job exposure and contributing to tenosynovitis. I have nothing in my notes at the time of [claimant's] visit to my office that there were other factors that were more significant in contributing to the tenosynovitis." (Emphasis added).

Although we are aware that a physician need not use "magic words," Mclendon v. Nabisco Brands, Inc,. 77 Or App 412 (1986), we view the absence of such words as highly probative when, as here, a physician is specifically asked but declines to use such words. Hurtado appears to have knowingly omitted the word "major" from his opinion. Ex. 18. In so doing, he opined that claimant's work activities were merely "a contributing factor." In occupational disease cases, however, as here, claimant must prove more than a mere contribution. She must prove that her work activities were "the major contributing cause" of her disease. See former ORS 656.802(1); Dethlefs, supra. For all the above reasons, we are not persuaded by Hurtado's opinion.

We turn to the opinion of Dr. Button. The Referee assigned little weight to Button's opinion because he found that it was based on "an incorrect and incomplete history." We disagree.

In fact, Button's report, dated December 31, 1986, Ex. 12, is one of only two medical reports contained in the record, which cogently explains claimant's medical history. See also Ex. 17. Unlike Button, Dr. Koehler provided no explanation of his understanding of claimant's medical history. Moreover, we find nothing materially "incorrect" or "incomplete" in Button's narrative of claimant's medical history. He had available and reviewed the records of Drs. Koehler and Hurtado. Dr. Button correctly noted that claimant had worked as a food service worker and cashier, that she had not sustained an injury, that she had experienced an onset of symptoms, and that she had increased her cashiering duties. In the light of that history, we do not find Button's understanding of claimant's history to undermine his opinion.

Accordingly, on this record, we find that the evidence does not preponderate in favor of a finding of compensability.

ORDER

The Referee's order, dated March 31, 1988, is reversed. The SAIF Corporation's denial is reinstated and upheld.

LESLY R. BURTON, Claimant
Gail Gage (SAIF), Defense Attorney

WCB 88-00146
November 20, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of those portions of Referee Brazeau's order that: (1) found that his compensable claim for injuries to his neck, left shoulder, and left leg was not prematurely closed by a Determination Order; (2) found that he was not entitled to an award of permanent total disability; and (3) affirmed a Determination Order that did not award either scheduled or unscheduled permanent disability for his neck, left shoulder, or left leg conditions. On review, the issues are premature claim closure, permanent total disability, and extent of both scheduled and unscheduled permanent disability.

The Board affirms the order of the Referee.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional finding.

Claimant suffers no permanent physical impairment in his neck, left shoulder, or left arm due to the December, 1985, compensable injury.

CONCLUSIONS OF LAW

The Board adopts the Referee's conclusions, save for his conclusions on the issue of the extent of claimant's scheduled and unscheduled permanent disability.

Extent of Scheduled and Unscheduled Permanent Disability

As an alternative to a finding of permanent total disability, claimant seeks awards of scheduled and/or unscheduled permanent disability. The former is measured by loss of use or function of the injured member, while the latter is measured by the loss of earning capacity. ORS 656.214(1) and (5). In either case, the alleged permanent disability must be due to the compensable injury. Id. It is claimant's burden to prove, by a preponderance of the evidence, entitlement to the awards he seeks. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

No medical expert has opined that claimant has any permanent physical impairment due to his compensable injury of December, 1985. In his latest report, dated October 5, 1987, Dr. Stolzberg diagnosed a "conversion reaction" and indicated that claimant's physical restrictions were temporary; not permanent. Although Dr. Regier, claimant's treating osteopath, suspected some "nerve damage" in the left shoulder and arm, he added that any such damage was objectively "undetected."

After "carefully" observing claimant's demeanor and comparing his alleged physical limitations to surveillance evidence, the Referee questioned claimant's veracity and found that he "exaggerates his symptoms." After our de novo review, we agree with the Referee's credibility assessment. See Pinkerton, Inc. v. Brander, 83 Or App 671, 674 (1987).

Furthermore, on this record, it is not clear whether claimant has intentionally exaggerated his symptoms or whether such exaggeration is due to a conversion reaction. What is clear, however, is that the issue of whether claimant suffers from a compensable conversion reaction is not before us. (Tr. 2). What is before us, is, inter alia, the issue of the extent of claimant's scheduled and unscheduled permanent disability. On this record, claimant has not proven that his subjective complaints of pain are, in fact, due to the compensable injury.

ORDER

The Referee's order, dated April 21, 1988, is affirmed.

MARY L. CEJKA, Claimant	WCB 87-05702
Merrill Schneider, Claimant's Attorney	November 20, 1989
Judy Johnson (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Zucker's order which: (1) affirmed a Determination Order award of 10 percent (32 degrees) unscheduled permanent disability for a low back injury; (2) upheld the SAIF Corporation's denial of chiropractic treatment in excess of two times per month; (3) assessed a 10 percent penalty and related attorney fee for untimely payment of temporary disability benefits; and (4) declined to assess penalties and related attorney fees for an alleged unreasonable failure to pay for medical services. On review, the issues are extent of permanent disability, reasonableness and necessity of medical treatment, and penalties and 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.

FINDINGS OF ULTIMATE FACT

As a result of her compensable low back injury, claimant has sustained permanent impairment in the minimal range.

As a result of her compensable injury, claimant suffered a 10 percent loss of earning capacity.

Chiropractic treatment in excess of two times per month is not reasonable and necessary.

SAIF's withholding payment of undisputed billings for medical services is unreasonable.

CONCLUSIONS OF LAW

We adopt the conclusions and reasoning as set forth in the "Opinion" section of the Referee's order in regard to the extent of permanent disability, reasonableness and necessity of chiropractic treatment in excess of two times per month and penalties and attorney fees for late payment of temporary disability.

In regard to SAIF's action of withholding payment of

undisputed billings from Dr. Bolera, the Referee found no legal basis for the action, but declined to assess penalties and related attorney fees on the basis that medical services were not "compensation." We disagree.

ORS 656.005(8) defines "compensation" as including all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer. In conjunction with this, ORS 656.262(10) provides for penalties if an insurer unreasonably delays or unreasonably refuses to pay compensation, and provides for a related attorney fee pursuant to ORS 656.382.

In the instant case, SAIF did not dispute Dr. Bolera's billings at the time of receipt and in fact paid the billings. It then audited the billings and decided that it would unilaterally withhold payment of undisputed treatment rendered after April 17, 1987 in order to recover earlier payments made that it perceived were inappropriate and not substantiated by documentation.

Assuming arguendo that SAIF's perception of Dr. Bolera's treatment is accurate, SAIF could have: (1) asked Dr. Bolera to supply justification of the billings within 30 days pursuant to OAR 436-10-040(2); (2) issued a partial denial of medical services within 60 days of receipt of the billings; or (3) appealed to the Medical Director pursuant to OAR 436-10-090(6)(a). It chose, however, to seek recovery on its own initiative by withholding payment of undisputed treatment rendered after its April 1987 letter to Dr. Bolera.

We conclude that SAIF's action was unreasonable. Further, SAIF has offered no explanation for its failure to pursue a remedy through proper channels. Accordingly, a penalty of 25 percent of all undisputed bills from Dr. Bolera that remain unpaid is assessed. Further, claimant's attorney is entitled to an insurer-paid fee pursuant to ORS 656.382.

ORDER

The Referee's order dated November 12, 1987, as amended December 18, 1987, is reversed in part and affirmed in part. That portion that did not assess a penalty and related attorney fee for the SAIF Corporation's witholding of payment to Dr. Bolera is reversed. SAIF is assessed a penalty equal to 25 percent of Dr. Bolera's outstanding, undisputed billings. Claimant's attorney is awarded a reasonable attorney fee of $500 for services at hearing and on Board review concerning the penalty issue, to be paid by SAIF. The remainder of the order is affirmed.

DELORES J. EDWARDS, Claimant	WCB 88-06228
Patrick Lavis, Claimant's Attorney	November 20, 1989
SAIF Corp Legal, Defense Attorney	Order on Review

Reviewed by Board Members Nichols and Crider.

The SAIF Corporation requests review of Referee Leahy's order that found that claimant was entitled to temporary partial disability benefits for missing work to attend weekly treatment sessions with her psychologist. On review, the issue is temporary partial disability. We reverse.

FINDINGS OF FACT

Claimant is employed by SAIF's insured as a homemaker. She filed a stress claim in 1987, which was denied. On January 8, 1988, a prior Referee set aside SAIF's denial. SAIF has subsequently processed the claim as a nondisabling injury claim.

Claimant has continued to work for the same employer and was released for work by her treating psychologist in February 1988. In April 1988, claimant's status remained unchanged. She was not medically stationary. At the time of hearing, the claim remained open.

Claimant was authorized by her psychologist to take off a week in March 1988, and SAIF provided time loss. Claimant sees her treating psychologist for approximately 50 minutes per week for treatment of her work related stress condition. To attend her sessions, claimant misses one and one-half hours of work per week.

The employer has deducted her weekly psychologist visits from her paycheck in the form of vacation, comp time, sick time or leave without pay. SAIF has not provided temporary disability benefits for claimant's weekly sessions with her psychologist.

CONCLUSIONS OF LAW

Reasoning that claimant's disability may be permanent, the Referee concluded that the statute which pertains to temporary disability, ORS 656.212, did not apply. The Referee therefore awarded temporary disability compensation for claimant's weekly psychological sessions on the grounds that OAR 436-60-020(7) did not prevent payment of temporary partial disability compensation to compensate for claimant's partial loss of earning power.

Claimant states that, for policy reasons, time loss from work for medical appointments should be compensated and in this case, economic stress from SAIF's failure to pay for weekly treatment sessions could result in a possible permanent medical condition. Claimant contends that this situation is controlled by ORS 656.212, and time loss for partial temporary disability should be compensated when she misses work for her doctor's appointments.

SAIF argues that ORS 656.212 is not applicable since the claimant is not stationary, but has returned to regular work. We agree.

ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

In Clifford D. Howerton, 38 Van Natta 1503 (1986), we found that an award of temporary disability compensation was not required when a claimant missed work to attend appointments with

his physician. We reasoned that an award of compensation for those days would be inconsistent with former OAR 436-60-020(7).

Former OAR 436-60-020(7) provides:

> "The period of time during which the worker must be absent from work to keep a medical appointment or have therapy treatment after being released to regular or modified work shall not be construed as loss of earning power as described under ORS 656.212. As such, the worker is not entitled to temporary disability compensation for these visits when the appointment or treatment is scheduled during the work shift."

In accordance with the Howerton rationale, we agree with SAIF and find that under former OAR 436-60-020(7), claimant is precluded from compensation since her absence from her work shift to attend weekly treatment sessions with her psychologist is not a loss of earning power under the statute.

ORDER

The Referee's order, dated May 17, 1988, is reversed.

DEWEY H. GILKEY, Claimant	WCB 84-13492, 85-10096, 85-10535 & 86-03407
Malagon & Moore, Claimant's Attorneys	November 20, 1989
Kate Donnelly (SAIF), Defense Attorney	Order on Review
John Littlefield, Defense Attorney	

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Brown's order that upheld denials by the SAIF Corporation and Liberty Northwest Insurance Corporation of his occupational disease claim relating to his left hip. The issues are compensability and responsibility. We reverse on the compensability issue and assign responsibility to SAIF.

FINDINGS OF FACT

Claimant began working for the employer in early 1974 as a driller. His primary task in this position was to drill holes in rock for the placement of explosives. To perform this task he had to carry a heavy drill and large drill bits over uneven ground to the job site. He then would set up the drill, operate it for several minutes, move it a few feet, operate it again and so on. In connection with his work, claimant also frequently carried heavy bags of explosives, drove truck, flagged traffic, cut brush and cleared ditches. He worked an average of 9 hours per day, 5 days per week.

In January 1975, claimant developed pain in his left hip after he slipped and fell in the course of his employment while carrying a heavy piece of equipment up a snowy embankment. The injury initially was diagnosed as a strain and was treated conservatively. SAIF, the insurer at the time, accepted claimant's claim for the injury. Claimant returned to work and his pain gradually increased. An inguinal hernia was identified and repaired in early 1976, but the hip pain continued. The claim

was closed by Determination Order in August 1976 with no award for permanent disability.

In early 1978, increasing left hip pain forced claimant to leave work and his claim was reopened. In November 1978, he was examined by Dr. Collis, an orthopedist, who noted degenerative changes in the left hip after comparing current x-rays with x-rays taken in April 1976. Dr. Collis identified this degenerative arthritis as the cause of claimant's pain. In May 1979, another orthopedist indicated that claimant's condition was nearing the point at which reconstructive surgery would be required. A dispute subsequently arose concerning whether the arthritis was causally related to claimant's 1975 industrial injury. In July 1979, a panel of the Orthopaedic Consultants noted congenital malformations in both of claimant's hip joints which made them susceptible to degeneration. SAIF issued a denial of the proposed left hip surgery in November 1979. The denial alleged that claimant's arthritis had preexisted the industrial injury and had worsened thereafter as a result of "natural progression." A Determination Order issued after the denial granted claimant a 15 percent unscheduled award for injury to his groin.

In May 1980, claimant and SAIF entered into a disputed claim settlement which was approved by former Referee Mannix on June 13, 1980. The settlement document identified the causal relation between claimant's left hip arthritis and the 1975 industrial injury as the focus of the dispute. It then provided that claimant would receive the sum of $4,000 and that SAIF's denial would remain in full force and effect. Also in May 1980, the parties entered into a stipulation whereby claimant's unscheduled disability award was increased to 27.5 percent.

Claimant returned to work as a driller in July 1980. He no longer drove truck because operating the clutch with his left leg was particularly hard on his hip. Claimant's left hip pain gradually increased during the next few years. On March 28, 1984, claimant visited another orthopedist, Dr. Bert. Dr. Bert diagnosed severe degenerative arthritis and recommended surgery for total hip replacement. SAIF, by letter to Dr. Bert dated April 12, 1984, refused to authorize the requested surgery based upon the June 1980 disputed claim settlement. A formal denial of an occupational disease was issued by SAIF on July 12, 1985. Claimant continued to work as a driller until September 17, 1985 when he underwent the surgery proposed by Dr. Bert. Thereafter he returned to work for the employer as a flagger. Claimant's off-work activity between June 1980 and September 1985 was primarily sedentary in nature.

The employer changed workers' compensation carriers from SAIF to Liberty Northwest on July 1, 1984. Claimant later filed a claim with Liberty Northwest which was denied in August 1985.

ULTIMATE FINDINGS OF FACT

1. Claimant's underlying left hip condition worsened between July 1980 and March 1984 more than it would have by virtue of the aging process alone. Claimant's work activity during that period was the major contributing cause of the worsening.

2. Claimant became disabled due to the worsened hip condition in March, 1984 when his need for surgery became immediate. At that time, SAIF was on the risk.

3. Work activities after March, 1984 did not independently contribute to claimant's left hip disability or any worsening of it.

CONCLUSIONS OF LAW

Compensability

The Referee identified three factors which contributed to the worsening of claimant's condition after June 1980: (1) the natural aging process; (2) the 1975 industrial injury; and (3) claimant's work activity. The Referee found the medical evidence insufficient to establish that claimant's work activity contributed more to the worsening of his condition than the other two factors. On that basis, he concluded that claimant's work activity was not the major contributing cause of the worsening and held claimant's condition not compensable.

On Board review, claimant contends that the Referee should have considered the effect of his 1975 industrial injury along with that of his work activity after June 1980 in determining whether employment activity was the major contributing cause of the worsening of his condition. See Kepford v. Weyerhaeuser Co., 77 Or App 363, rev den 300 Or 722 (1986). SAIF argues that the Referee could not consider the effect of the 1975 industrial injury on claimant's degenerative hip condition because the June 1980 disputed claim settlement established as a matter of law that there was no such effect. We need not decide this issue because, even accepting SAIF's argument, we conclude that claimant has proven a compensable occupational disease.

Under SAIF's theory of the case, claimant's degenerative hip condition as it existed in June 1980 was completely the result of noncompensable causes. Assuming this to be true, claimant has the burden of proving that his work activity after June 1980 was the major contributing cause of a worsening of his underlying condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979); Blakely v. SAIF, 89 Or App 653, 656 (1988). It is undisputed that claimant's underlying degenerative hip condition worsened after June 1980, and that this worsening was due at least in part to claimant's work activity. The focus of inquiry, therefore, is whether claimant's work activity, other than the specific injury in 1975, was the major contributing cause of the worsening.

The only medical professional to give an opinion regarding the cause of the worsening of claimant's condition after June 1980 was Dr. Bert, claimant's treating orthopedist. Dr. Bert opined that the major factor leading to the degeneration of claimant's left hip joint was the trauma associated with the 1975 industrial injury. (Ex. 71-23). He thought that this injury had altered or damaged the joint, thus making it unusually susceptible to degeneration from further trauma or use. (See Ex. 71-11). The second most important factor identified by Dr. Bert in the degeneration of claimant's left hip condition was the heavy use of the joint associated with claimant's work activity. (Ex. 71-17 to 18, 71-24). Dr. Bert also indicated that off-work activity could be a factor. He did not have much information about the nature of claimant's off-work activity, (see Ex. 71-18), but was asked to assume that it was much less strenuous than his work activity.

Under this assumption, Dr. Bert opined that claimant's off-work activity would be a contributing factor, but only a minor one. (Ex. 71-24). Claimant's testimony at the hearing established the accuracy of this assumption. (See Tr. 19 to 22).

Assuming in accordance with SAIF's argument that the effect of the trauma associated with claimant's 1975 industrial injury must be attributed to noncompensable causes by virtue of the June 1980 disputed claim settlement, that effect cannot be considered a causative factor for purposes of an occupational disease analysis. The effect of the 1975 injury, even if noncompensable as a matter of law, was part of claimant's physical makeup when he returned to work in July 1980. An employer takes a worker as it finds him with all his inherent defects. Surratt v. Gunderson Brothers, 259 Or 65, 74 (1980); Keefer v. SIAC, 171 Or 405, 412 (1943). A claimant's physical makeup, therefore, cannot be considered a causative factor for purposes of a major contributing cause analysis even though it may be such from a medical perspective.

The same principle applies to the "natural aging process" factor which was considered by the Referee in his analysis. Dr. Bert indicated on a number of occasions that a certain amount of degeneration of the hip joints is normal in the average person. (See Ex. 50, 51, 71-19, 71-22). To the extent that this "natural aging process" refers to the effects of structural or idiopathic aspects of claimant's physical makeup, it cannot be considered as a causative factor in the major contributing cause analysis. To the extent that it refers to the effects of claimant's work and off-work activities, it duplicates and jumbles the other factors identified by Dr. Bert. At best, therefore, consideration of the "natural aging process" distorts the analysis.

In view of the above discussion, we conclude that the only two causative factors which may be considered for purposes of the major contributing cause analysis are the last two identified by Dr. Bert: claimant's work activity and his off-work activity. Of these two, claimant's work activity was the greater cause of the worsening of his condition. We conclude, therefore, that claimant has established that his work activity was the major contributing cause of the worsening and that he has proven a compensable occupational disease.

Responsibility

Responsibility for occupational diseases is governed by the "last injurious exposure rule." Bracke v. Baza'r, Inc., 293 Or 239, 246 (1982). The carrier on the risk when the condition becomes disabling is initially responsible if that work activity could have contributed to the condition. However, that carrier may shift responsibility to a subsequent carrier by showing that conditions during the subsequent carrier's period of employment actually did contribute to the cause or worsening of the claimant's underlying condition. See Bracke v. Baza'r, Inc., supra, 293 Or at 250-51; see also Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984). That is, responsibility will shift if work activities for a subsequent employer independently contribute to claimant's disability. Spurlock v. International Paper Co., 89 Or App 461 (1988).

The date of disability in this case was March 28, 1984, the date when claimant first received medical services from Dr. Bert for his worsened condition. SAIF was the carrier on the risk in March 1984, and claimant's employment at that time involved potentially causal conditions. SAIF is thus initially responsible. As discussed earlier, however, SAIF may shift responsiblity to Liberty Northwest if SAIF can prove that claimant's employment activity after Liberty Northwest came on the risk in July 1984 actually contributed to the worsening of claimant's underlying condition.

The evidence clearly establishes that claimant's work activity from July 1980 to March 1984 caused a worsening of his underlying condition. (See Ex. 71-17). The most that the evidence would permit us to find concerning claimant's work activity after Liberty Northwest came on the risk on July 1, 1984, however, was that it caused a worsening of the symptoms of claimant's condition, (Ex. 70, 71-18), and could have contributed to a worsening of the underlying condition. (Ex. 71-8, 71-19). We read the evidence to establish that claimant's symptoms worsened after July 1, 1984 but did not in fact pathologically worsen thereafter. This is insufficient to shift responsibility under the last injurious exposure rule. See Boise Cascade v. Starbuck, supra, 296 Or at 243; Bracke v. Baza'r, Inc., supra, 293 Or at 250-51; Spurlock v. International Paper Co., supra; Industrial Indemnity v. Weaver, 81 Or 493 (1986). Responsibility, therefore, remains with SAIF.

ORDER

The Referee's order dated January 30, 1987 is reversed. The SAIF Corporation's denials dated April 12, 1984 and July 12, 1985 are set aside and claimant's claim is remanded to SAIF for processing according to law. Liberty Northwest Insurance Corporation's denial dated August 16, 1985 is upheld. Claimant's initial attorney of record is awarded $1,000 for services prior to the hearing, to be paid by SAIF. Claimant's subsequent attorney of record is awarded $4,200 for services at the hearing and on Board review, to be paid by SAIF. Counsel for Liberty Northwest is authorized to charge a client-paid fee of up to $160.

ELMER C. GREGORY, Claimant	WCB 85-02269
Martin J. McKeown, Claimant's Attorney	November 20, 1989
Kevin L. Mannix, Defense Attorney	Order on Review

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Black's order which upheld the self-insured employer's denial of "further chiropractic treatment." On review, the issue is medical services. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in 1980. He underwent surgery in May 1983 and December 1985. Claimant has a history of chiropractic treatments related to this injury, but had not had any for over a year prior to treating with Dr. Stearns in early 1987.

Dr. Stearns reported, in February 1987, that claimant required frequent chiropractic treatments for a worsening of his

condition, which were especially necessary to allow claimant to remain working. Several other doctors disagreed with Dr. Stearns' opinion that such treatments were needed.

Claimant has been receiving treatments from one to three times per week since January 1987. Generally, he gets one to two days relief from each treatment. These treatments permit him to continue working.

On June 12, 1987, the employer issued a denial of those medical services which stated:

> "This letter is to inform you as required by Section 656.262 of the Oregon Workers' Compensation law, that it is our position to deny further chiropractic treatment."
>
> Based on the Independent Medical Examiner's report, we feel that further chiropractic care is not reasonable, necessary or attributable to your industrial injury. This is a partial denial only." (Emphasis in original).

CONCLUSIONS OF LAW AND OPINION

An employer/insurer may not deny future responsibility for payment of benefits relating to a previously accepted claim. Evanite Fiber Corporation v. Striplin, 99 Or App 353 (November 8, 1989). See Robert M. Bryant, 41 Van Natta 324 (1989). Here, inasmuch as the employer's denial is prospective, it shall be set aside.

Alternatively, on the merits, we also find that the treatments are reasonable and necessary. Claimant has had two compensable surgeries and his treating surgeon, Dr. Collada, opines that claimant's treatment should continue, even though it is just palliative. We consider the treating surgeon's opinion to be particularly persuasive. Moreover, the chiropractic treatments permit claimant to continue working. See West v. SAIF, 74 Or App 317, 321 (1985). Under these circumstances, we conclude that these medical services are reasonably and necessarily incurred.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated December 24, 1987, is reversed. The self-insured employer's June 12, 1987 denial is set aside and the claim is remanded for further processing according to law. A client-paid fee, payable from the employer to its counsel, not to exceed $1290, is approved.

GERALD J. HOLMES, Claimant
Robert Chapman, Claimant's Attorney
Charles Lisle (SAIF), Defense Attorney

WCB 86-03668
November 20, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Mongrain's order that: (1) found that claimant was not a subject worker for Kellum Brothers; and (2) reversed a Director's order declaring Kellum Brothers to be a noncomplying employer. On review, the issue is subjectivity.

We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, including his "supplemental finding" that all the conditions of work for Kellum Brothers applicable to Richard Goodrich were similarly applicable to claimant. In making this supplemental finding, we assume the Referee was referring to claimant's work installing vinyl. The conditions of claimant's carpet installation work were different than those of Mr. Goodrich. Claimant was paid by Mr. Goodrich for his carpet installation work, whereas Mr. Goodrich was paid by Kellum Brothers.

We make the following additional findings of fact.

Kellum Brothers had carpet installation agreements with several carpet installers in addition to Mr. Goodrich. It neither employed nor had labor agreements with any workers other than Mr. Goodrich, claimant and these other carpet installers.

FINDINGS OF ULTIMATE FACT

Claimant, in his role as carpet installer, was not a "subject worker" of Kellum Brothers under former ORS 656.005(28) and 656.027.

CONCLUSIONS OF LAW AND OPINION

This case is on appeal from a Director's order which found Kellum Brothers to be a noncomplying employer because it employed claimant as a subject worker without complying with ORS 656.017. Kellum Brothers has the burden to prove that the order was incorrect. ORS 656.740(1).

The Referee ruled that Kellum Brothers had demonstrated that claimant was not a "subject worker" under the common law codified at former ORS 656.005(28) and 656.027. Claimant challenges that ruling on review. In the alternative, claimant contends that he is otherwise "deemed to be a subject worker" under former ORS 656.029, Oregon's so-called statutory employer law. The Referee failed to address the possible application of this provision.

We adopt the Referee's conclusion that Kellum Brothers demonstrated that claimant was not its "subject worker" within the meaning of former ORS 656.005(28) and 656.027. However, Kellum Brothers has not demonstrated that claimant was not its subject worker under Oregon's statutory employer law. See former ORS 656.029. This law was designed to place ultimate

responsibility for workers' compensation coverage with a principal contractor who has the ability to choose a subcontractor, insist upon appropriate compensation protection, and pass on the responsibility of coverage. See E. W. Eldridge, Inc. v. Becker, 73 Or App 631 (1985). At the time of claimant's injury, the pertinent sections of ORS 656.029 read as follows:

> "(1) If any person engaged in a business and subject to [Chapter 656] as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let has qualified either as a carrier-insured employer or a self-insured employer."
>
> "(3) A person who files the declaration of status as an independent contractor is not eligible to receive benefits under [Chapter 656] unless the individual has obtained coverage for such benefits pursuant to ORS 656.128. The filing of a declaration of status pursuant to this section creates a rebuttable presumption that the person is an independent contractor."
>
> "(4) A person . . . engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, who [files for certification as an independently established business] is conclusively presumed to be an independent contractor and is not eligible to receive benefits under [Chapter 656] unless the person has obtained coverage for such benefits pursuant to ORS 656.128."

In enacting ORS 656.029, the legislature intended to eliminate the need to decide in each case whether a person is a subject worker under the common law codified at former ORS 656.005(28) and 656.027. See Kistner v. BLT Enterprises, Inc., 74 Or App 131 (1985); Love v. Northwest Exploration Co., 67 Or App 413, 417 (1984). If the conditions of ORS 656.029(1) are satisfied, claimant is deemed to be the subject worker of Kellum Brothers unless he has filed a declaration of status as an independent contractor or has applied for certification as an independently established business.

Kellum Brothers can avoid application of former ORS 656.029(1) in this case by demonstrating any one of the following: (1) that it was not a "person . . . subject to [Chapter 656] as an employer" at the time of claimant's injury; (2) that it did not "let a contract" to Mr. Goodrich within the meaning of former ORS 656.029(1); (3) that Mr. Goodrich was

qualified as a self-insured or carrier-insured employer at the time of the injury; (4) that claimant filed a declaration of status as an independent contractor (unless rebuttal evidence shows that he was not); or (5) that claimant had filed for certification as an independently established business.

In order to demonstrate that it was not a "person . . . subject to [Chapter 656] as an employer", Kellum Brothers must show that it had no "subject workers" under the common law codified at former ORS 656.005(28) and 656.027. See ORS 656.023; Konell v. Konell, 48 Or App 551, 557-558 (1980). As discussed above, we agree with the Referee's determination that claimant, in his role as carpet installer, was not Kellum Brothers' subject worker under the common law. Furthermore, the record contains evidence that Mr. Goodrich and claimant in his role as vinyl installer were subcontractors, rather than subject workers under the common law. However, Kellum Brothers had carpet installation agreements with several other workers at the time of claimant's injury. There is insufficient evidence in the record to determine whether those workers were subject workers under the common law. Accordingly, we conclude that Kellum Brothers has not carried its burden of proving that it had no "subject workers" under the common law.

We further conclude that Kellum Brothers has not demonstrated that it did not "let a contract" to Mr. Goodrich within the meaning of former ORS 656.029(1). We previously discussed this issue at some length in our decision in Todd A. Aucone, 38 Van Natta 552 (1985). There we stated that the nature of the employment agreement was the principal criteria in determining whether a contract had been "let" within the meaning of ORS 656.029. The work to be performed must be of a nature that might typically be "let" as that term is used in common parlance. The more directly related the work is to the employer's principal business, the more likely the work is of a nature that might typically be "let." The actual process by which the agreement is entered into is one indication of the nature of the agreement, but is not necessarily controlling. Neither a formal bidding process nor a written agreement is essential, but contracts that are "let" are typically circumspectly entered into. See also Kistner v. BLT Enterprises, Inc., supra; Marvin C. Wright, 39 Van Natta 105 (1988); affirmed Bernards v. Wright, 93 Or App 192 (1988); Richard F. Erzen, 36 Van Natta 218 (1984), affirmed 73 Or App 256 (1985).

Here, the agreement was for installation of carpet in customers' homes. Installation of carpeting was an integral part of Kellum Brothers' business. It included installation in the price of its carpeting, and it advertised its carpet as installed. Mr. Goodrich worked for Kellum Brothers nearly every day, 20 to 60 hours per week, and Kellum Brothers utilized several other carpet installers. Although there is no evidence that Mr. Goodrich participated in a formal bidding process, Kellum Brothers can be presumed to have some familiarity with the going rates for carpet installation and to have entered into its arrangement with Mr. Goodrich "circumspectly." Finally, the arrangement between Kellum Brothers and Mr. Goodrich was customary in the carpet business, and Kellum Brothers referred to Mr. Goodrich as its "subcontractor." In light of these factors, we conclude that Kellum Brothers did "let a contract" to Mr. Goodrich within the meaning of former ORS 656.029(1).

We further conclude that Kellum Brothers has not demonstrated that claimant had filed a declaration of status as an independent contractor, or filed for certification as an independently established business. Both Mr. Goodrich and claimant testified that claimant was not licensed in Oregon to do work as an independent business, and there is no evidence in the record to the contrary. Similarly, we conclude that Kellum Brothers has not demonstrated that Mr. Goodrich was qualified as a self-insured or carrier-insured employer at the time of claimant's injury. Mr. Goodrich testified that he did not carry workers' compensation insurance, and there is nothing in the record that would lead us to find otherwise.

Consistent with the above discussion, we conclude that Kellum Brothers has failed to demonstrate that former ORS 656.029 is not applicable in this case. The Director's order is prima facie correct and has not been proven incorrect. Accordingly, we reverse the Referee's subjectivity ruling and conclude that claimant is deemed to be Kellum Brothers' subject worker under ORS 656.029.

Finally, claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated November 27, 1987, as amended January 15, 1988, is reversed in part and affirmed in part. That part of the order that reversed an order issued by the Workers' Compensation Department declaring Kellum Brothers to be a noncomplying employer is reversed. The Department's order is reinstated and affirmed. The remainder of the order is affirmed.

RAY LITTLEFIELD, Claimant	WCB TP-89016
Bischoff & Strooband, Claimant's Attorneys	November 20, 1989
Allen, Kilmer, et al., Defense Attorneys	Order Denying Abatement

It has come to our attention that a copy of our October 23, 1989 Third Party Partial Distribution Order may not have been received by the paying agency's counsel. Although nothing in the record suggests that a copy of our order was not mailed to the agency's counsel, we mailed another copy of the order to the paying agency's counsel on November 1, 1989. We have received no further response from the agency's counsel since mailing the additional copy of the order.

Pending its receipt of the aforementioned copy of our October 23, 1989 order, the paying agency seeks abatement of our order. The motion for abatement is denied. An attorney is not a party and thus mailing to an attorney is not statutorily required. See ORS 656.005(19); Berliner v. Weyerhaeuser Co., 92 Or App 264, 266, n 1 (1988); Frank F. Pucher, Jr., 41 Van Natta 794 (1989). Thus, even if the Board's order was improperly mailed to the paying agency's counsel, there is no contention that a copy was not mailed to the "party" itself i.e., the paying agency. Moreover, any potential prejudice occasioned

by the agency's counsel's initial failure to receive a copy of the Board's order has been remedied by our mailing of another copy of the order to him on November 1, 1989.

IT IS SO ORDERED.

STEVEN NICHOLS, Claimant
Marc Kardell, Claimant's Attorney
Arthur Stevens (SAIF), Defense Attorney
Alice Bartelt, Defense Attorney

WCB 87-08973 & 87-19243
November 20, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Melum's order that: (1) upheld the SAIF Corporation's "aggravation" denials; (2) upheld Travelers Insurance's "new injury" denial; and (3) declined to assess a penalty and attorney fee against either or both insurers for their allegedly unreasonable delays in denying compensability and responsibility.

ISSUES

1. Whether claimant has established a compensable aggravation or "new injury."

2. If compensable, whether SAIF or Travelers is responsible for claimant's current disability.

3. Whether SAIF or Travelers unreasonably delayed denying compensability and responsibility.

FINDING OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

SAIF's May 4, 1981 denial of claimant's aggravation claim denied a relationship between his compensable injury two years earlier and his then-current back problems. That denial became final.

CONCLUSIONS OF LAW

Compensability

The Board adopts that portion of the Referee's opinion that found claimant had not established either a compensable aggravation or "new injury." We additionally note that, although not conclusive, the Referee's conclusion is supported by the fact that claimant's back condition in May 1981 was, as a matter of law, unrelated to his compensable injury. It is not apparent whether Dr. Campagna either knew or appreciated the significance of that fact.

Responsibility

Given our above finding that claimant has not proven compensability, we need not address the issue of responsibility. Runft v. SAIF, 303 Or 493, 498-99 (1987); see Joseph W. Woodward, 39 Van Natta 1163 (1987).

Penalties and Attorney Fees

The Referee found that inasmuch as claimant's aggravation rights under ORS 656.273 had expired, SAIF "was not required to respond" to claimant's aggravation claim. We disagree.

ORS 656.273(3) provides: "A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." After the worker files an aggravation claim, the insurer has 60 days in which to accept or deny the claim or risk the imposition of penalties and attorney fees. ORS 656.262(6) & ORS 656.262(10). The mere fact that the worker's aggravation rights under ORS 656.273 have expired does not vitiate the insurer's statutory duty to timely accept or deny the worker's aggravation claim. Although the insurer may properly deny reopening after expiration of the five-year period, see ORS 656.273(4) et seq. & ORS 656.278(4), the worker is nevertheless entitled to a timely acceptance or denial of his claim. ORS 656.262(6).

Here, on November 16, 1986, SAIF received a medical report from Dr. Renaud, M.D. In that report, Renaud informed SAIF that: (1) claimant had been unable to work since his increased low back pain of November 22, 1985; (2) there was evidence of a herniated nucleus pulposus at the L4-5 level; and (2) claimant was to be hospitalized for a myelogram and CT scan. Yet, SAIF did not deny the compensability of claimant's lumbar disc until April 9, 1987; i.e., well beyond the 60-day period.

Under such circumstances, we find that SAIF unreasonably delayed the denial of claimant's aggravation claim. However, because there are no "amounts then due", under ORS 656.262(10), we cannot assess a penalty. Furthermore, because the claim was not compensable and no compensation was owed, we find no unreasonable resistance to the payment of compensation under ORS 656.382(1). Ellis v. McCall Insulation, 308 OR 74(1989); Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989).

Lastly, finding nothing unreasonable or untimely about Travelers' denial of claimant's "new injury" claim, Exs. 12 & 28, we decline to assess a penalty or attorney fee.

ORDER

The Referee's order, dated February 18, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that declined to find that SAIF had unreasonably delayed issuing a denial of claimant's aggravation claim is reversed. All remaining portions of the Referee's order are affirmed.

MARILYN A. ROBINSON, Claimant	WCB 81-05065
Pozzi, et al., Claimant's Attorneys	November 20, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Podnar's order which upheld the self-insured employer's denial of claimant's medical services claim for an athletic club membership; reimbursement for mileage to the athletic club; reimbursement for swim-wear; and household assistance. With her appellant's brief,

claimant has submitted additional evidence not otherwise in the record and requests that we remand to the Referee for consideration of the submitted documents. On review, the issues are compensability and remand. We decline to remand and affirm.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

The record has not been improperly, incompletely, or otherwise insufficiently developed.

Dr. Zimmerman did not maintain direct control or supervision over claimant's swimming therapy.

CONCLUSIONS OF LAW

Remand

Claimant requests that we remand this case for the taking of further evidence in regard to an aggravation claim. We decline to do so and adopt the Referee's conclusions and reasoning as set forth in the "Post Hearing Motion" section of his order.

Compensability of Athletic Club Membership

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

Athletic club memberships are subject to former OAR 436-10-050(2), which requires the attending physician to maintain direct supervision or control over treatment provided by non-licensed providers. Kelly B. Worden, 41 Van Natta 1758 (October 18, 1989); Stephen J. Culver, 39 Van Natta 653 (1987).

Here, Dr. Zimmerman prescribed swimming therapy for claimant's low back condition. There is no evidence, however, that he maintained any direction or supervision over the swimming therapy. Accordingly, the athletic club membership is not compensable. Worden, supra.

As we have found the athletic club membership not compensable, it follows that the mileage reimbursement and the swim-wear reimbursement are also not compensable.

Compensability of Household Assistance

We adopt the Referee's conclusions and reasoning. See Lorenzen v. SAIF, 79 Or App 751 (1986).

ORDER

The Referee's order, dated May 18, 1988, is affirmed. A client-paid fee, not to exceed $884, is approved.

ROBERT J. SALING, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-15197 & 85-13694
November 20, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Howell's order that: (1) set aside the self-insured employer's denials of claimant's claims for a neck, right shoulder, and low back condition insofar as they were based on an "aggravation" theory; and (2) upheld the employer's denials for the same conditions to the extent the claims represented "new injuries." On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On January 24, 1975, claimant was employed as a dryer tender when he was compensably injured while attempting to clean a moisture meter machine. The injury occurred when the conveyor belts came on by accident causing claimant to take a twisting fall, and pulling his left arm into a pinch roller. As a consequence, claimant experienced a crushing injury to his left hand and elbow requiring medical treatment. This injury resolved with no permanent impairment.

After this accident, claimant returned to work for the same employer as a dryer tender and later as a forklift driver. Six to eight months after the compensable 1975 injury, he began to experience symptoms of dizziness and left chest complaints. At this time, he experienced no low back problems.

Sometime later, between six months to a year after the 1975 compensable injury, claimant began experiencing additional symptoms, primarily of low back pain, and to a lesser degree upper back and right shoulder pain. On April 22, 1976, claimant began treating with a chiropractor, Dr. Schaeffer, for back and neck pain, and pressures in the head. This medical care was paid for initially by a private carrier, and, beginning in 1981, by claimant. Treatment continued throughout the years on a periodic basis. As a result, claimant was able live a normal and productive life.

On or about September 5, 1985, claimant was driving a forklift when he hit a pothole causing his neck to snap back. He experienced a "flash of lightning." Due to the injury, claimant had symptoms of pain in the shoulder, low back, hips and knees. He also complained of burning in the shoulder blades, numbness and tingling in the arms and legs, aching all over the back and neck area, throbbing head, dizziness, chest pains, and pressure in the head. As a result, claimant required intensive chiropractic care.

A claim was filed on September 5, 1985 for this injury. The employer denied the claim on October 31, 1985. This claim was denied because the employer related claimant's current condition to a preexisting condition and not the result of work activities.

On August 22, 1986, claimant experienced a similar incident. He was driving the forklift when he hit a large pothole. On this occasion, claimant experienced immediate low back pain and left leg numbness. As a result, claimant required

numerous chiropractic treatments due to his increased pain and limitations.

Claimant filed a claim on August 28, 1986 for this injury. The employer denied the claim on October 28, 1986. The basis of this denial was twofold: (1) no relationship between claimant's condition and his work activities; and (2) failure to report the claim in a timely manner. Claimant requested a hearing.

At the time of hearing, claimant was seeing Dr. Schaeffer once a month for treatment. Claimant's condition has not returned to the pre-injury stage. He now experiences left leg problems and an increased level of neck, right shoulder, and low back pain. In addition, his work activities have been limited. Claimant is no longer able to drive a forklift, and he is restricted to light work. Presently, he is working in the light duty position of "edge glue offbearer."

ULTIMATE FINDINGS OF FACT

"Claimant's neck, right shoulder and low back conditions preexisted the September 5, 1985 and August 22, 1986 work incident. Claimant's compensable injury in 1975 did not materially contribute to those conditions. As a result of the work incidents in September 1985 and August 1986, those conditions symptomatically worsened, causing increased disability and need for medical treatment."

CONCLUSIONS OF LAW

The Referee concluded that the September 1985 and August 1986 injuries were not "new injuries," but rather, aggravations of the 1975 compensable injury. Therefore, the Referee set aside the October 31, 1985 and October 28, 1986 denials to the extent they denied compensability of claimant's neck, right shoulder, and low back conditions as an aggravation of the 1975 compensable injury, upheld the denials to the extent they denied claims for "new injuries," and remanded for processing under ORS 656.273 and/or ORS 656.278. We disagree.

The causation of claimant's condition is of sufficient medical complexity that we cannot decide it without expert opinion. See Kassahn v. Publishers Paper, 76 Or 105 (1985). 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).

Claimant's treating physician, Dr. Schaeffer, has opined that the current neck, right shoulder, and low back condition is an aggravation of the 1975 compensable injury. His opinion is premised on the assumption that the neck, right shoulder, and low back condition arose at the time of the 1975 injury. Dr. Schaeffer made this causal connection, not at the inception of treatment for these symptoms in April 1976, but rather after the September 5, 1985 exacerbation.

On the other hand, the Orthopaedic Consultants found no causal connection between claimant's condition and the 1975 compensable injury. Their opinion is based on the lack of medical evidence pointing to such a relationship, and the length of time

between the January 1975 injury and the initial onset of symptoms some six months to one year later.

We find the opinion of the Orthopaedic Consultants better reasoned, and hence, more persuasive on the issue of causation of claimant's condition. Dr. Schaeffer's opinion relies upon the faulty medical history that claimant's preexisting condition arose at the time of the 1975 compensable injury. There is no persuasive medical or lay evidence that claimant's condition is causally related to the 1975 compensable injury. Claimant did not experience symptoms until six months to one year after the event.

Secondly, Dr. Schaeffer was not the treating physician for the 1975 compensable injury. He did not begin treating claimant until 14 months after the event in April 1976. Even then, he does not make a causal connection to a work-related injury until 10 years later. Thus, we do not find that Dr. Schaeffer is in any better position to evaluate causation of claimant's condition than the Orthopaedic Consultants. Accordingly, we give Dr. Schaeffer's opinion with respect to causation little weight.

Therefore, we do not find persuasive medical evidence of a causal connection between claimant's neck, right shoulder, and low back condition and the 1975 compensable injury. Accordingly, we do not consider the 1985 and 1986 incidents to be aggravations of the 1975 compensable injury. However, we do consider these incidents to be compensable exacerbations of claimant's preexisting nonindustrial condition.

In order to establish a compensable injury, claimant must prove that his work was a material contributing cause of his disability. Summit v. Weyerhaeuser Co., 25 Or App 851 (1976). Although an injury may not have worsened the preexisting condition, but precipitated symptoms causing disability or requiring medical services, that is sufficient to make the symptomatic worsening compensable. Claimant need not prove that the compensable injury caused a pathological worsening of his preexisting neck, right shoulder and low back condition in order to establish a compensable claim. See Jameson v. SAIF, 63 Or App 553, 555 (1983). Rather, he need only show that the compensable injury caused claimant's condition to become symptomatic, causing disability or requiring medical services. Grace v. SAIF, 76 Or App 511, 517 (1985); Brain C. Roll, 40 Van Natta 2046 (1988).

The medical record shows that sometime between six months to a year after the 1975 compensable injury claimant began experiencing symptoms in the neck, right shoulder, and low back for which he sought treatment from Dr. Schaeffer. Throughout the years claimant has received periodic care. This care successfully controlled the symptoms and allowed claimant to lead a normal productive life.

As a result of the September 1985 and August 1986 incidents claimant's preexisting condition became symptomatic, requiring increased and intensive chiropractic treatment. He experiences a greater level of increased pain in the neck, shoulder and back areas. In addition, he now has problems with his left leg with weakness, atrophy, and occasional numbness and tingling. Since the injuries, claimant has yet to return to his pre-injury status.

Claimant also experiences reduced earning capacity. Prior to the injuries, claimant was able to perform his job as forklift driver without restriction or limitation. Since the injuries, he is no longer able to drive a forklift and is restricted to a light duty position.

Accordingly, we find the 1985 and 1986 injuries made claimant's preexisting neck, right shoulder, and low back condition symptomatic to the point that the condition became disabling and required medical services. We therefore find claimant's condition compensable.

Claimant's counsel is entitled to a reasonable carrier paid fee for prevailing on the denied claims. See ORS 656.386(1); OAR 438-15-055(2). However, we cannot award an "assessed" fee unless claimant's counsel files a statement of services. OAR 438-15-005(2); 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order, dated September 17, 1987, is reversed. The self-insured employer's denials of claimant's neck, right shoulder, and low back condition are set aside, and the claim is remanded for processing as a "new injury" claim. The remainder of the Referee's order is affirmed. A client-paid fee is approved, payable from the self-insured employer to its counsel, not to exceed $375.

GLORIA A. SEVERSON, Claimant	WCB 87-13614
Coons & Cole, Claimant's Attorneys	November 20, 1989
Norman Cole (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of Referee Mulder's orders that awarded claimant's attorney an insurer-paid attorney fee for services which culminated in the Director's order directing SAIF to provide further vocational assistance. We affirm.

ISSUES

1. Jurisdiction. Does the assessment of an insurer-paid attorney fee for SAIF's alleged unreasonable resistance to the provision of vocational training present a question concerning a claim?

2. Attorney Fees.

(a) Did claimant prevail finally in a hearing before the Referee or on Board review from an order or decision denying a claim for compensation?

(b) If not, was SAIF's refusal to provide vocational training an unreasonable resistance to the payment of compensation?

FINDINGS OF FACT

Claimant, 54, compensably strained her upper back and right shoulder on September 18, 1984, while working as a custodial worker. At that time, claimant had preexisting permanent

impairment with underlying cervicodorsal and right shoulder degenerative joint disease and rotator cuff tendinitis. Claimant previously injured the right shoulder at work in March, 1980, for which she ultimately received a 5 percent permanent partial disability award.

The September 1984 injury claim was closed by Determination Order on May 17, 1985, with 30 percent unscheduled permanent disability. The award was later increased to 45 percent unscheduled permanent disability by Stipulation and Order on December 1, 1986.

SAIF referred claimant for vocational assistance in April, 1986. At the time, claimant's overall physical impairment was mild with limitations on lifting, pushing, pulling, walking, standing and sitting. Those limitations preclude her return to the job-at-injury. Claimant is a high school graduate with prior work experience as a lumber camp cook, waitress, laundry worker, fry cook and hospital cleaner. A direct employment plan was developed with the vocational goals of counter attendant, check room/canteen attendant, general office clerk, mail order clerk, waitress and club/restroom attendant. Starting hourly wages in those vocations ranged from $3.35 to $4.26, whereas the hourly wage currently being paid for a custodial worker at claimant's level is $7.09. Claimant received intensive job search skills training and considerable instruction regarding her personal hygiene. Claimant pursued a clerical position with her employer at injury, but she failed the state clerical examination. Her vocational counselor provided her over 20 leads on clerical positions, but she was not qualified for any of them.

In September, 1986, claimant's vocational counselor recommended that her vocational file be closed, describing her poor appearance and personal hygiene as a "detriment" to her reemployment. Vocational assistance was terminated.

In December, 1986, claimant's attorney wrote SAIF a formal request for further vocational assistance in the form of vocational training. That request was denied. In May, 1987, claimant requested the Director's review of SAIF's action regarding vocational assistance. Following his review, the Director found claimant eligible for training and ordered the development and implementation of a training plan. Claimant was assigned to training in July, 1987.

FINDINGS OF ULTIMATE FACT

Claimant did not prevail finally in a hearing before a Referee from an order or decision denying her claim for compensation.

SAIF's refusal to provide vocational training was an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing on the issue of whether she is entitled to an assessed fee, i.e., insurer-paid attorney fee, for legal representation on the Director's review which culminated in the Director's July 8, 1987 Review and Order directing SAIF to provide claimant with vocational training. Claimant asserted entitlement to the fee under either ORS 656.382(1) or

ORS 656.386(1). The Referee awarded claimant the assessed fee, apparently under ORS 656.386(1). We agree that an assessed fee is appropriate, but award it under ORS 656.382(1).

Jurisdiction

SAIF contends that the Referee lacked jurisdiction to consider claimant's hearing request for an assessed fee. SAIF argues that the assessed fee issue is a matter regarding vocational assistance for which claimant must first apply to the Director for administrative review. We disagree.

ORS 656.283(1) provides that, "[s]ubject to subsection (2) of this section ***, any party *** may at any time request a hearing on any question concerning a claim." Subsection (2) of that section provides that "[i]f a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must first apply to the director [i.e., the Director of the Department of Insurance and Finance] for administrative review of the matter before requesting a hearing on that matter." Hence, a Referee properly has jurisdiction of any question concerning a claim, except in those cases where claimant is dissatisfied with the insurer/employer's action regarding vocational assistance.

We are persuaded that claimant's assessed fee request presents a "question concerning a claim." It is undisputed that claimant has an accepted injury claim with SAIF. It is further undisputed that, in processing claimant's claim, SAIF was statutorily required to determine her need for assistance in returning to work. See former ORS 656.340(1). An assessed fee may be imposed against SAIF for an unreasonable resistance to the payment of compensation. See ORS 656.382(1). "Compensation" includes "all benefits, including medical services, provided for a compensable injury" to the worker by an insurer or employer. Former ORS 656.005(9) (now ORS 656.005(8)). By its plain meaning, "all benefits provided...by an insurer " includes vocational assistance. See ORS 686.005(9). It follows, therefore, that an assessed fee may be imposed for an unreasonable resistance to the provision of vocational assistance. Because SAIF's conduct in providing vocational assistance is a matter concerning claimant's claim, the reasonableness of that conduct is similarly a matter concerning her claim.

We are further persuaded that claimant's assessed fee request is not a matter "regarding vocational assistance" within the meaning of ORS 656.283(2). Claimant's entitlement to or participation in vocational assistance is not at issue here. Rather, the issue is whether SAIF unreasonably resisted the provision of vocational assistance. Therefore, the focus of the inquiry is on the reasonableness of SAIF's conduct in processing claimant's claim. The entitlement to or nature of vocational assistance is tangential to that inquiry. Therefore, we conclude that the Referee properly had jurisdiction of claimant's request for hearing on an assessed fee.

We are aware of previous Board cases where the Board has held that it lacks jurisdiction to assess a penalty for the insurer/employer's unreasonable delay in referring claimant for vocational assistance. E.g., Steven M. DeMarco, 38 Van Natta 886 (1986); James T. Harvey, 37 Van Natta 960 (1985); Ray Moore,

37 Van Natta 466 (1985); Joel I. Harris, 36 Van Natta 829 (1984), aff'd mem 72 Or App 591 (1985). In each of those cases, the Board concluded that the Director had been given exclusive jurisdiction to assess a penalty for the insurer/employer's allegedly unreasonable conduct regarding vocational assistance. To support that conclusion, the Board cited ORS 656.745 and rules promulgated thereunder, which authorize the Director to assess a civil penalty against an employer or insurer for, inter alia, making it necessary for a claimant to resort to proceedings against the insurer/employer to secure compensation due. The Board implicitly reasoned that, by empowering the Director to assess civil penalties under the circumstances described in ORS 656.745, the legislature necessarily intended to exclude the Board from assessing penalties in like circumstances.

We need not comment on the correctness of those decisions, because they are distinguishable from this case. Whereas those cases involved the assessment of a penalty, this case involves the assessment of an attorney fee. In contradistinction to the Director's authority regarding civil penalties, the Director has no authority to impose an assessed fee. In light of that distinction, the reasoning applied in the cited cases has no application here.

Entitlement to an Assessed Fee under ORS 656.386(1)

ORS 656.386(1) provides in relevant part that a Referee or the Board shall assess an insurer-paid attorney fee where claimant "prevails finally" in a hearing before the Referee or in a review by the Board "from an order or decision denying the claim for compensation." See Shoulders v. SAIF, 300 Or 606, 611-12 (1986). Claimant contends that her attorney's letter of December 16, 1986 requesting further vocational assistance amounted to a claim for compensation, and that SAIF's refusal to provide the same amounted to a "decision denying the claim for compensation." She further contends that, although the Director granted her further assistance, she did not "prevail finally" before him because he declined to award her an assessed fee. She reasons that she did not "prevail finally" until this Referee awarded her the assessed fee. She then concludes that, because she finally prevailed before the Referee, she is entitled to an assessed fee under ORS 656.386(1). Claimant's reasoning is circular and misconstrues the language of ORS 656.386(1).

Contrary to claimant's implicit assertion, ORS 656.386(1) does not authorize an assessed fee for merely prevailing on any matter connected with her claim for compensation. The statute requires more. Claimant must prevail on the issue of compensability, i.e., her entitlement to compensation. See Shoulders v. SAIF, supra. Even if we accepted claimant's argument that her attorney's request for further vocational assistance was a claim for compensation and that it was denied by SAIF, it nevertheless remains clear that she finally prevailed over that denial of compensation before the Director, not the Referee. ORS 656.386(1) does not authorize an assessed fee for prevailing before the Director. Moreover, attorney fees are not "benefits" or "compensation" within the meaning of the Workers' Compensation Law. Dotson v. Bohemia, Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986). Hence, the assessment of an attorney fee does not present an issue of compensability. We find, therefore, that claimant did not

"prevail finally" before the Referee for purposes of ORS 656.386(1). Claimant is not entitled to an assessed fee under ORS 656.386(1).

Entitlement to Assessed Fee under ORS 656.382(1)

ORS 656.382(1) authorizes the assessment of an attorney fee if the insurer "refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation." We have already concluded that vocational assistance is "compensation" as that term is defined in former ORS 656.005(9). The remaining inquiry is whether SAIF unreasonably resisted the provision of further vocational assistance. We conclude that it did.

The objectives of vocational assistance are "to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as possible to the worker's wage at the time of injury." Former ORS 656.340(6). The employer/insurer must provide a direct employment plan (DEP) if it finds direct employment services necessary and sufficient for the worker to achieve earlier return to work or to obtain suitable employment. Former OAR 436-120-100(1). "Suitable employment" means, inter alia, employment of the kind for which the worker has the necessary knowledge, skills and abilities, providing a wage as close as possible to the wage currently being paid for the worker's employment at injury. Former OAR 436-120-005(7)(a),(b). The employer/insurer must offer a training plan to the worker if, inter alia, the DEP is not sufficient for the worker to obtain suitable employment, other than because of the condition of the labor market. Former OAR 436-120-120(1)(a).

We are persuaded that the vocations identified for the DEP were not suitable. They were not of the kind for which claimant has the necessary knowledge, skills and abilities. They all require considerable clerical skills and/or public contact. Claimant is not competitive in clerical work, because she acquired her clerical training over 30 years ago and has not worked in that field since then. She failed the state clerical examination and was not qualified for positions to which she was referred by her vocational counselor. Moreover, although claimant has prior work experience involving public contact, her lack of public contact skills is well documented in the vocational reports. Her vocational counselor made numerous reference to claimant's poor physical appearance, grooming and personal hygiene. Indeed, the counselor later recommended closure of claimant's vocational file, describing her appearance as a "detriment" to her reemployment.

Furthermore, the vocations identified for the DEP did not provide starting wages comparable to the wage currently being provided for claimant's employment at injury, i.e., custodial worker. Those vocations offer starting wages ranging from $3.35 to $4.26. That is far lower than the $7.09 hourly wage that claimant could be earning as a custodial worker.

Because the DEP was inadequate to return claimant to suitable employment, SAIF should have referred claimant for vocational training. See former OAR 436-120-120(1)(a). Following our review of this record, we find that SAIF did not have a legitimate basis for refusing to refer claimant for vocational training. Accordingly, we find that its refusal to do so was

unreasonable. See Peterson v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986). Accordingly, an assessed fee was properly imposed.

Amount of Assessed Fee

The Referee awarded claimant an assessed fee of $500 in his original order dated March 14, 1988. He then approved an assessed fee of $425 by Order Approving Fees dated March 25, 1988. SAIF argues that the latter order superseded the original order, while claimant argues that the original assessed fee award of $500 should be affirmed.

We conclude that the order dated March 14 dealt with attorney fees. Since the order of March 25 does not purport to alter or republish the prior order, the orders appear to be cumulative. However, as only one fee is appropriate, we find that the March 14 order award was appropriate and set aside the March order.

ORDER

The Referee's order dated March 14, 1988 is affirmed. The March 25, 1988 order is set aside.

LINDA L. SMITH, Claimant	WCB 86-16686
Roll, et al., Claimant's Attorneys	November 20, 1989
Acker, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Peterson's order that set aside its partial denial of claimant's anxiety condition. On review the issue is compensability.

The Board affirms with the following supplementation.

FINDINGS OF FACT

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

Claimant did receive medical services for her anxiety condition stemming from the pain in her shoulder and inability to function normally. Dr. Steinmann, her treating physician, recommended methods to relieve her stress. (Ex. 28b-2).

Claimant's anxiety condition was disabling as demonstrated by episodes of depression, crying, and difficulty sleeping. (Tr. 41-43)

FINDING OF ULTIMATE FACT

Claimant's compensable right shoulder injury was a material contributing cause of her anxiety disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions of Law with the following supplementation.

An injured worker is entitled to all reasonable and necessary medical services for a compensable injury. ORS 656.245. In order to prove compensability of medical services, the compensable injury need not be the sole cause, or the most significant cause of the need for treatment, but rather a material cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987). The fact that a diagnosed condition only requires medical services and is nondisabling does not necessarily mean that the condition is not compensable. Johnson v. Hamilton Electric, 90 Or App 161 (1988).

ORS 656.005 does not define "medical services." The court in Finch v. Stayton Canning Co., 93 Or App 168 (1988), while pointing out that there is no definition for the term "medical services" as found in ORS 656.005(7)(a), held that the claimant who had symptoms, and sought the assistance of a physician for treatment even though no actual treatment was recommended, had received the required "medical services" and suffered a compensable occupational disease. The court said, "That no treatment is available for an injury or disease does not mean that a claimant is not injured or sick." id at 173.

Here, claimant, while receiving medical services for her compensable shoulder injury, sought her treating physician's advice with regard to her anxiety and stress stemming from the shoulder pain and her inability to function normally. These problems manifested themselves through episodes of depression, crying, and sleeping difficulties. Dr. Steinmann, her physician, did not prescribe specific medical treatment but recommended methods, specific to her needs, to relieve her anxiety. We conclude that the physician's consultation regarding claimant's anxiety was "medical services" for the purpose of ORS 656.005(8).

Moreover, we find the symptoms stemming from claimant's anxiety (depression, crying and sleeping difficulties), to be disabling.

Accordingly, we agree with the Referee that claimant's anxiety condition was materially related to her compensable right shoulder injury. Therefore, the denial should be set aside.

ORDER

The Referee's order dated April 1, 1988, as reconsidered May 23, 1988, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $625, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $1339.50.

FRANK L. STODDARD, Claimant — WCB 84-10872
Emmons, Kyle, et al., Claimant's Attorneys — November 20, 1989
Brian L. Pocock, Defense Attorneys — Order on Review

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Seymour's order that: (1) upheld insurer's denial of modifications and removal of architectural barriers in claimant's home; and (2) declined to assess penalties and attorney fees for an alleged unreasonable resistance or failure to pay for a home air conditioner. The insurer cross-requests review of that portion of the order that: (1) set aside its denial of claimant's surgery

claim; (2) set aside its denial of claimant's claim for home air conditioning; (3) set aside its denial of repairs for claimant's van; (4) set aside its denial of physical rehabilitation equipment; and (5) awarded carrier-paid attorney fees of $3,000. The insurer also moves the Board to consider additional evidence regarding claimant's proposed surgery, or alternatively, to remand. Since we have no authority to review evidence that was not first considered by the Referee, we treat the insurer's motion as one for remand. We deny the motion and affirm the Referee's order.

ISSUES

(1) Payment for modifications and removal of architectural barriers in claimant's home;

(2) Payment for air-conditioning in claimant's home;

(3) Penalties and attorney fees for failure to pay for claimant's home air conditioning;

(4) Denial of surgery;

(5) Payment for repair of claimant's van;

(6) Payment for physical rehabilitation equipment;

(7) Attorney fees payable to claimant in the amount of $3,000;

(8) Remand for additional evidence on the issue of claimant's proposed surgery.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Findings and Opinion" section of the Referee's order, with the following supplementation:

Claimant, since his divorce, has had full time assistants to help him in his home. At the present time, claimant is unable to use the shower in his home, due to architectural barriers.

FINDINGS OF ULTIMATE FACT

Claimant requires attendant care at home. The removal Of architectural barriers is not a reasonable and necessary medical service.

CONCLUSIONS OF LAW

We adopt those portions of the Referee's opinion concerning the issues of claimant's van, physical rehabilitation equipment, surgery and penalty and attorney fees. We address the issues of remand, architectural barriers and home air conditioning.

Request for remand

Under ORS 656.295(5), the Board 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 or heard by the referee." To merit remand, claimant must establish that material evidence was unobtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

A hearing was held on February 10, 1987, and the record was held open to receive evidence until July 28, 1987. From March through June, 1987, depositions were taken from claimant's doctors and from a doctor who performed an independent medical examination upon claimant. The insurer seeks to obtain remand, based upon a January, 1988 independent medical examination and report by a fourth physician.

We find that this case was sufficiently developed and heard by the Referee. Moreover, the insurer has failed to show that, with due diligence, it could not obtain the doctor's report before the hearing. We therefore deny the insurer's request to remand this matter for consideration of the post-hearing medical report of a second independent medical examiner.

Removal of architectural barriers

The Referee upheld the insurer's denial of funds for the modifications and removal of architectural barriers in claimant's house. The Referee found that claimant was not entitled to such expenditures because the services were not of the same kind or class as those specifically enumerated in ORS 656.245(1). We agree with the Referee's ruling, but base our decision upon the following grounds.

Medical services are compensable provided they are reasonably and necessarily incurred in the treatment of the compensable injury. West v. SAIF, 74 Or App 317, 320 (1985); McGarry v. SAIF, 24 Or App 883, 888 (1976). In the present case, removal of the architectural barriers would allow claimant to take a shower, but would not allow him to live without attendant care.

Although we agree that the use of shower facilities would provide some degree of independence for claimant, the record does not show that claimant would be able to perform this or other tasks without the assistance of caregivers. Thus, there is no need to decide whether such a service is covered under ORS 56.245(1), since even if it were covered, the service would not be reasonable and necessary in this case.

Home air conditioning

The Referee found that air conditioning for claimant's residence was a medical necessity and the insurer, even though it had once paid for the service, was obligated to pay for it again when claimant subsequently moved to another residence. We agree, but base our conclusion upon the following reasoning.

The provision of air conditioning was reasonable and necessary in light of the fact that claimant had moved to a new residence because of divorce, and because it had been 15 years since the insurer had purchased the first air conditioner.

ORDER

The Referee's order dated August 19,1987 is affirmed. For services on review concerning the insurer's cross-request (except the attorney fee issue), claimant's attorney is awarded an assessed fee of $1,100, to be paid by the insurer. A client-paid fee, not to exceed $560, is approved.

DAVID L. VORDERSTRASSE, Claimant — WCB 86-14401
Emmons, et al., Claimant's Attorneys — November 20, 1989
Kevin L. Mannix, Defense Attorney — Order on Review

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Garaventa's order which upheld the insurer's denial of medical services and its denial of both an aggravation claim and an occupational disease claim. The insurer cross-requests review from that portion of the Referee's order which awarded a carrier-paid attorney's fee for "clarifying" a denial. We affirm in part and reverse in part.

ISSUES

The first issue is whether claimant has proven by a preponderance of the evidence that the medical services, which he obtained in August 1986, are attributable to his accepted wrist injury.

The second issue is whether claimant has proven by a preponderance of the evidence that his Raynaud's phenomenon is a compensable occupational disease.

The final issue is whether claimant is entitled to a carrier-paid attorney's fee for "clarifying" a denial which is otherwise upheld.

FINDINGS OF FACT

Claimant compensably injured his right wrist on March 5, 1982. Claimant suffered a chronic right wrist sprain. The claim was accepted as nondisabling. Claimant sought additional medical treatment for a sore right wrist in late 1983. The insurer denied compensability of the medical treatment and an aggravation claim on March 14, 1984. By stipulation of December 20, 1984, the insurer agreed to pay for treatment of both the left and right wrists. The parties agreed that claimant had no permanent impairment and was entitled to no time loss benefits.

In August 1986, claimant saw Dr. Ellison for pain, numbness and reduced circulation in both hands. Dr. Ellison diagnosed Raynaud's phenomenon. The insurer then issued a denial of medical services on October 13, 1986. The denial stated that claimant's compensable injury had not aggravated. It stated that claimant's "ulnar neuropathy" was unrelated to the compensable injury.

The insurer issued a second denial on December 8, 1986. That denial stated in relevant part:

> "[W]e...supplement that denial to specify that not only are your current wrist problems not attributable to your 1986 employment....Your

1986 wrist problems appear to be in the nature of a disease process. Thus any claim you are presenting regarding the 1986 problems is in the nature of an occupational disease claim. Your work activity...is not the major contributing cause of any current condition in your wrists and hands, nor is it the major contributing cause of any worsening of underlying conditions in your wrists and hands.

"Thus, we are denying any aggravation of your prior industrial injury claims and we are denying any present (1986) occupational disease claim."

Claimant's accepted injury has no causal relationship to the problems he had in 1986 which are the subject of this case.

Claimant has Raynaud's phenomenon. Claimant's work activities were the major cause of the Raynaud's phenomenon. Claimant had no underlying condition which was worsened by his work activities. Raynaud's phenomenon is a temporary spasm of the blood vessels of the hands which causes the hands to feel cold and turn either blue or white. The primary medical treatment for this phenomenon is to avoid the activities which cause it; however, occasionally surgery is performed. Claimant does not need surgery. Raynaud's phenomenon does not represent an irreversible change in the tissues of the hands. The only way Raynaud's phenomenon is manifested is by the characteristic symptoms.

CONCLUSIONS

There is no persuasive evidence that claimant's accepted injury bears any relationship to the problems he had in 1986. Accordingly, to the extent that the denials deny that claimant's compensable injury contributed to his problems in 1986, they are correct.

The Referee concluded that claimant has a medical condition (Raynaud's phenomenon), but that it has required no treatment and, therefore, is not compensable because it has not required medical treatment or caused disability. We disagree with that conclusion. Claimant clearly sought treatment from Dr. Ellison because of pain and numbness in his hands. Dr. Ellison attempted to diagnose the problems and also referred claimant to Dr. Throop for additional diagnostic treatment. The fact that the only treatment available for the Raynaud's phenomenon is to stop doing the activities which cause it does not mean that claimant's attempt to have the problem diagnosed and treated is not compensable. See Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987).

The insurer argues that Raynaud's phenomenon is not a disease because it is merely a symptomatic condition. We disagree. Although Dr. Button states that there is no pathological change, he also explains that Raynaud's phenomenon is more than symptoms. It is an actual, albeit temporary, spasm of the blood vessels of the hands which causes them to turn blue or white and to feel cold. In other words, the work caused temporary physical changes in claimant's hands. We find Dr. Button's description of the process more persuasive than his refusal to describe it as pathological. We conclude that Raynaud's

phenomenon is a disease and that it is compensable because claimant's work is the major cause of it.

Because the Referee concluded that the Raynaud's phenomenon was caused by claimant's work, she clarified the denial to specify that it was caused by the work, albeit not compensable. The Referee awarded an insurer-paid attorney's fee because she clarified the employer's denial. We need not address the appropriateness of the Referee's action because our decision on the occupational disease denial moots the necessity of clarifying the denial.

ORDER

The Referee's order, dated November 12, 1987, is affirmed in part and reversed in part. The insurer's denial of claimant's Reynaud phenomenon claim 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 aforementioned claim, claimant's attorney is awarded a reasonable attorney's fee of $2,000, to be paid by the insurer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,009, is approved.

GALE J. WARREN, Claimant — WCB 87-15662
Starr & Vinson, Claimant's Attorneys — November 20, 1989
Cummins, Cummins, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of Referee Young's order that set aside its denial of claimant's occupational disease claim for her bilateral carpal tunnel syndrome. On review, the issue is compensability.

We affirm.

FINDINGS OF FACT

Claimant has worked in plywood mills for the past eight to ten years. She began working in the employer's mill in May 1987. Prior to that time, she had experienced no problems with her hands or wrists. She initially worked for the employer as a utility person, was laid off after three weeks, and returned a short time later to work exclusively as a dryer feeder. The latter job required claimant to move wet wood from a cart onto a conveyor. The job involved repetitive grasping, pulling and twisting with both hands. There is no evidence that claimant's off-work activities involved repetitive, strenuous use of her hands.

Shortly after beginning work as a dryer feeder, claimant developed aching in both hands and wrists. She continued to work, her pain increased, and she developed numbness, tingling and swelling in both hands. Her symptoms increased to the point that she sought treatment from her family physician, Dr. Beckwith. He referred her to Dr. Schachner, orthopedic surgeon, who diagnosed carpal tunnel syndrome and recommended surgery. Serial nerve conduction studies performed in September 1987 identified a bilateral abnormal focal slowing approximately two to three centimeters distal from the wrist crease.

Claimant filed an occupational disease claim with the employer in August 1987. The claim was denied, and she requested a hearing.

FINDINGS OF ULTIMATE FACT

Claimant's symptoms are attributable to carpal tunnel syndrome, which is defined as a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel. Claimant's work activities with the employer were the major contributing cause of the onset or worsening of her carpal tunnel syndrome.

CONCLUSIONS AND OPINION

The employer contends that the Referee erred in concluding that claimant had demonstrated a compensable occupational disease. We disagree.

Claimant must demonstrate that her work with the employer was the major contributing cause of the onset or worsening of her occupational disease. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Dethlefs v. Hyster Co., 295 Or 298 (1983); Weller v. Union Carbide, 288 Or 27 (1979). Here, the pivotal issue is whether claimant's "occupational disease" is the slowing in the median nerve identified in electrodiagnostic tests, or the clinical condition, described as "carpal tunnel syndrome," resulting from compression and oxygen deprivation of the median nerve.

The causation issue in this case is the type of complex medical question that requires expert medical analysis. The record contains relevant medical opinions from treating orthopedic surgeon Schachner and Dr. Nathan, hand surgeon. The opinions of both medical experts support the following findings and conclusions. First, claimant experienced no difficulties with her hands or wrists before she began working for the employer. Second, claimant's work with the employer was the major contributing cause of her current bilateral wrist and hand symptoms. Third, those symptoms are attributable to "carpal tunnel syndrome," defined as a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel.

Accordingly, if "carpal tunnel syndrome" is the "occupational disease" in this case, claimant has demonstrated a compensable disease. However, the employer disagrees with this characterization of claimant's disease. It relies, instead, on an alternative definition put forth by Dr. Nathan, who performed an independent medical examination in September 1987. If we accept Dr. Nathan's opinion, claimant has not demonstrated a compensable occupational disease. He defined claimant's disease as the slowing of the median nerve identified in electrodiagnostic tests. He further opined that this nerve slowing was entirely ideopathic in origin and was not worsened by claimant's work activity.

The Referee rejected Dr. Nathan's opinion and concluded that claimant's carpal tunnel syndrome was a compensable occupational disease. We agree. In order to be compensable, an occupational disease must require treatment or result in

disability or death. ORS 656.804 and former 656.005(8)(a). Claimant is not seeking treatment for a slowing of the median nerve but for her clinical condition, characterized as carpal tunnel syndrome. Dr. Nathan concedes that treatment of claimant's median nerve slowing would be inappropriate in the absence of symptoms, i.e., until the onset of carpal tunnel syndrome. Furthermore, when treatment is provided, it does nothing to correct the underlying slowing of the median nerve but merely relieves symptoms by allowing more blood and oxygen to reach the nerve. Finally, claimant's condition is disabling because of her symptom complex, not the slowing of her median nerve.

After considering these factors, we conclude that claimant' carpal tunnel syndrome is a compensable occupational disease. Accordingly, we affirm the Referee's decision on this issue.

ORDER

The Referee's order dated January 7, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $637.50 for services on review, to be paid by the self-insured employer. The Board approves a client-paid fee for the self-insured employer's attorney, not to exceed $1,273.

JOHN R. WATTS, Claimant	WCB 87-19057
Merrill Schneider, et al., Claimant's Attorneys	November 20, 1989
Schuyler T. Wallace, Jr., Defense Attorney	Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Bennett's order that assessed an attorney fee of $75 for the insurer's late payment of temporary disability and medical services compensation. A higher attorney fee is sought by claimant. Although the insurer has not formally cross-requested review, it argues in its brief that: (1) claimant was time-barred from raising the penalty and attorney fee issue; (2) the assessment of a penalty was improper because its delay in the payment of claimant's compensation was not unreasonable; and (3) the attorney fee awarded to claimant at the hearing was excessive. On review, the issues are timeliness, the assessment of a penalty, and the amount of claimant's attorney fee.

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

The insurer argues that "ORS 12.100(2)" barred claimant from seeking a penalty and attorney fee for its late payment of temporary disability benefits and medical service expenses. We disagree. We are bound by the Workers' Compensation Law as set forth in ORS Chapter 656. ORS Chapter 12 has no application to timeliness matters within contested workers' compensation cases. Moreover, it is axiomatic that specific statutes control over those of mere general application. Here, in this workers' compensation case, the statutes contained in ORS Chapter 656 are more specific than those in ORS Chapter 12.

ORS 656.262(6) provides that a worker has 60 days in which to appeal from a denial. In Roger G. Prusak, 40 Van Natta 2037, 2040 (1988), the Board interpreted

ORS 656.262(6) to provide no time limit for the filing of a request for hearing to contest a "de facto" denial. Here, the denial of claimant's temporary disability benefits and medical services expenses was a "de facto" denial. See Barr v. EBI Companies, 88 Or App 132, 136 (1987). Accordingly, the fact that claimant did not file his request for hearing within 60 days from the "de facto" denial, does not time-bar his request. Roger G. Prusak, supra.

ORDER

The Referee's order, dated March 15, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,462.50.

WILLIAM E. WOOD, Claimant	WCB 86-26273 & 87-04717
Bennett, Hartman, et al., Claimant's Attorneys	November 20, 1989
Cummins, et al., Defense Attorneys	Order on Review (Remanding)

Reviewed by Board Members Howell and Perry.

Claimant requests review of those portions of Referee Galton's order which: (1) upheld the self-insured employer's denial of his low back injury claim; and (2) set aside the employer's partial denial of continuing medical services under a prior claim. Claimant contends that the Board should remand the case to the Referee with instructions to order the production of a video tape for possible inclusion in the record. The employer cross-requests review of that portion of the Referee's order which set aside the employer's partial denial of medical services. The issues on review are remand, compensability, and medical services.

FINDINGS OF FACT

Prior to hearing, the employer stated that it had a surveillance video tape that it intended to introduce at hearing. Claimant requested disclosure of the video tape, but the employer refused, stating that the tape would only be used for impeachment purposes. After claimant had testified at the hearing, the employer said it would not offer the tape.

Claimant requested disclosure of the video tape. The tape was delivered to claimant during the course of the all-day hearing on August 6, 1987. The employer refused to disclose who made the tapes and the Referee did not address a motion by claimant to order such disclosure.

At the conclusion of the hearing on August 6, 1987, claimant had not yet reviewed the video tape. He moved for a very short continuance to view the tape and determine if he wished to offer it into evidence. The employer objected on the grounds that it would require that a foundation be laid if the tape was to be offered. The Referee denied claimant's motion and closed the record.

Claimant asserts that he subsequently viewed the tape and requested reopening of the record and receipt of the tape into evidence. The Referee refused to reopen the record.

CONCLUSIONS OF LAW AND OPINION

The Board may remand a case to the Referee if it determines

that a case has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5).

We have previously held that a party may not withhold evidence to be used "for impeachment purposes" and subsequently not offer it at the hearing. Kenneth K. Kessel, 39 Van Natta 416, 417 (1987); former OAR 438-07-015.

In Kessel, we remanded to the Referee with instructions that the insurer disclose the withheld documents to claimant's attorney unless it had another valid reason for not doing so. Claimant was to be allowed a reasonable time to examine the documents and offer them into evidence if he so chose.

In this case, we find that claimant was not given a reasonable time to examine the tape and make a determination if he wished to offer it into evidence. Furthermore, the employer's objection to a continuance because of delay which might have resulted from claimant having to lay a foundation for the tape was ill founded. The employer did not disclose the tape until the time of hearing. And, it had the information necessary for a foundation for introduction of the tape, but refused to disclose all or part of it to claimant.

We find Kessel to be controlling in this case. Accordingly, we remand.

ORDER

The Referee's order dated August 14, 1987 is vacated and the case is remanded to the Referee for further proceedings consistent with this order. The employer is directed to disclose the surveillance tape and any information necessary for introduction into evidence of the tape to claimant's attorney, unless it can convince the Referee that it has some other valid reason for non-disclosure. Upon disclosure, claimant is to be allowed a reasonable time to examine the tape and to decide whether he wishes to offer the tape into evidence. If claimant wishes to offer the tape into evidence, the tape and any foundation evidence shall be received. The Referee shall then reconsider this case in light of the new evidence, if any is offered. A client paid fee, not to exceed $1,324, is approved.

HAROLD G. BUSH, Claimant	Own Motion 88-0818M
Pozzi, et al., Claimant's Attorneys	November 21, 1989
Argonaut Insurance, Insurance Carrier	Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his November 27, 1979 industrial injury. Claimant's aggravation rights have expired. Claimant is requesting temporary total disability compensation for his knee condition and vocational assistance.

Under ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Here, the record submitted to the Board fails to demonstrate that claimant requires surgery or hospitalization for

treatment. Furthermore, the Board has no authority to award vocational services in own motion claims. Claimant may petition Rehabilitation Review Section of the Workers' Compensation Division in regard to this matter. See ORS 656.340; OAR 436-120-210. Accordingly, the request for own motion relief is denied.

Entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

RUDOLFO CHAVEZ, Claimant
Brian R. Whitehead, Claimant's Attorney
Kevin L. Mannix, Defense Attorney

WCB 87-18506
November 21, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee Higashi's order which: (1) found that the January 1988 Determination Order prematurely closed claimant's claim; (2) found that claimant was entitled to temporary disability benefits from March 27, 1987 through November 5, 1987; (3) assessed a penalty and associated attorney fee for unreasonable failure to pay temporary disability benefits from March 27, 1987 through November 5, 1987; and (4) awarded claimant's counsel an attorney fee for obtaining unemployment compensation. Claimant cross-appeals that portion of the order which allowed the insurer to offset previously paid permanent disability against temporary disability benefits awarded by the Referee's order. On review, the issues are premature closure, temporary disability benefits, penalties, attorney fees, and offset. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Findings" section of the Referee's order.

FINDINGS OF ULTIMATE FACT

Claimant was not medically stationary when the January 1988 Determination Order closed his claim.

Claimant was not medically stationary on March 27, 1987.

The insurer did not act unreasonably in terminating claimant's temporary disability benefits on March 27, 1987.

CONCLUSIONS OF LAW

Premature Closure

We adopt the Referee's conclusions and reasoning.

Temporary Disability Benefits

We agree with the Referee's conclusion, however we modify his reasoning.

ORS 656.268 requires temporary disability benefits to be

paid, unless a claimant is both released to work and medically stationary. See e.g. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 on recon, 93 Or App 103 (1988), rev den 307 Or 236 (1989). Here, Dr. Van Hee released claimant for work on March 27, 1987. At that time, however, he opined that claimant was not medically stationary. Therefore, claimant is entitled to temporary disability benefits between March 27, 1987 and November 5, 1987. Fazzolari, supra; Doris L. (Crist) McCullough, 41 Van Natta 1075 (1989).

Penalties and Attorney Fees

The Referee concluded that the insurer acted unreasonably in not paying temporary disability benefits from March 27, 1987 through November 5, 1987 and awarded a penalty and related attorney fee. We disagree.

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's actions must be gauged based upon the information available to the carrier at the time of its action. Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Here, the insurer terminated claimant's temporary disability benefits based upon Dr. Van Hee's March 27, 1987 release to work. It resumed payment when Dr. Van Hee rescinded the release to work on November 5, 1987. At the time the insurer terminated claimant's temporary disability benefits, the prevailing case law supported the insurer's action. See Volk v. SAIF, 73 Or App 643 (1985). Accordingly, at the time it terminated claimant's temporary disability benefits, the insurer's action was in reliance on the applicable law and was not unreasonable. Under these circumstances, a penalty is not warranted.

Attorney Fee

The Referee awarded a carrier-paid attorney fee for claimant's counsel's efforts in obtaining unemployment compensation on the basis that it was offset against temporary disability benefits. We disagree.

Attorney fees awarded pursuant to a workers' compensation claim are governed by ORS 656.382 through 656.388. Inherent in these provisions is the requirement that an attorney be instrumental in gaining or protecting compensation. Compensation for the purposes of Chapter 656 includes "all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." ORS 656.005(8).

Here the Referee awarded a carrier-paid fee for services rendered in gaining claimant unemployment compensation. Unemployment compensation is not an enumerated benefit provided by or under the terms of Chapter 656. Accordingly, the Referee had no authority to award such an attorney fee.

Offset

The Referee concluded that since he had set aside the

Determination Order as premature, the insurer was entitled to offset permanent partial disability paid pursuant to the Determination Order against temporary disability benefits created by his order. We disagree.

ORS 656.268(10) provides that an offset may be granted for overpaid temporary disability benefits against future awards of permanent disability benefits. However, it does not allow previously paid permanent disability benefits to be offset against future temporary disability benefits. See Harold D. Bates, 38 Van Natta 992 (1986) (Board Member Ferris dissenting). Accordingly, the insurer was not entitled to the offset granted by the Referee.

ORDER

The Referee's order, dated June 8, 1988, is reversed in part and affirmed in part. That portion which granted a penalty and attorney fee for unreasonable nonpayment of temporary disability benefits is reversed. That portion which granted claimant's counsel a $300 attorney fee for services rendered in obtaining unemployment compensation is reversed. That portion which authorized the insurer to offset previously paid permanent disability is reversed. The remainder of the order is affirmed. For services rendered on Board review concerning the premature closure and temporary disability benefits issues, claimant's counsel is awarded an insurer-paid fee of $600. A client-paid fee, not to exceed $1,683, is approved.

RUDOLFO CHAVEZ, Claimant
Brian R. Whitehead, Claimant's Attorney
Kevin L. Mannix, Defense Attorney

WCB 88-17656
November 21, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Harri's order which: (1) found he was without jurisdiction to enforce a Referee's award of an insurer-paid attorney fee; (2) declined to assess a penalty and related attorney fee for alleged unreasonable failure to comply with the Referee's order. On review, the issues are jurisdiction and penalties and attorney fees.

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

This date we have reversed that portion of the order, in WCB Case No. 87-18506, which granted the insurer-paid attorney fee at issue. We concluded that the first Referee was without authority to award an attorney fee to claimant's counsel for obtaining unemployment compensation because unemployment benefits are outside the authority of a Workers' Compensation Referee under Chapter 656.

Our order in WCB Case No. 87-18506 lends further support for the Referee's conclusion that, because the first Referee lacked authority to award the insurer-paid fee, he was without authority to direct the insurer to comply with that Referee's order. Moreover, considering the first Referee's lack of authority, we find that the insurer's failure to comply with the order was not unreasonable.

ORDER

The Referee's order, dated February 24, 1989, is affirmed. A client-paid fee, not to exceed $1,040, is approved.

RAMON A. GUTIERREZ, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 88-02837
November 21, 1989
Order on Review (Remanding)

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Seymour's order dismissing claimant's request for hearing. Claimant seeks to have the dismissal set aside and for an order remanding the case to the Hearings Division for either a hearing on the merits or a hearing to determine whether claimant had justification for failing to appear at hearing. We reverse and remand.

FINDINGS OF FACT

Claimant filed a request for hearing through his attorney on February 24, 1988. In the documents accompanying the request for hearing, claimant's address was listed as a post office box in Woodburn, Oregon. The Hearings Division sent a Notice of Informal Dispute Resolution Conference to claimant at that address sometime after the request for hearing was received. On March 2, 1988, the Hearings Division sent claimant a Notice of Hearing at the same address. The hearing was scheduled for May 10, 1988. Claimant's attorney responded to the Informal Dispute Resolution Notice in a document received on March 14, 1988. The insurer responded to the request for hearing on April 20, 1988. Its response sought to have the award granted by Determination Order reduced.

On May 10, 1988, the insurer's attorney and one of claimant's attorneys appeared at hearing. Claimant did not appear at hearing. Claimant's attorney offered to submit claimant's case on the record. The insurer moved to dismiss claimant's request for hearing. He also agreed to dismiss the insurer's cross-request without prejudice. The Referee cited former OAR 438-06-071 as authority and indicated on the record that he would dismiss claimant's request for hearing. On May 11, 1988, the Referee issued an order of dismissal, again relying on former OAR 438-06-071 for authority.

CONCLUSIONS AND OPINION

The Referee relied on former OAR 438-06-071 which states:

> "Failure of a party or the party's representative to appear at the time and place scheduled for a hearing is a waiver of appearance. If the party that fails to appear is the party that requested the hearing, the referee shall issue an order dismissing the request for hearing for failure to appear unless a postponement is granted under 438-06-081."

Former OAR 438-06-081 allows postponements only upon a showing of extraordinary circumstances. It includes examples of circumstances which are not extraordinary circumstances.

We conclude that the Referee was incorrect in dismissing the hearing request based on claimant's failure to appear at the hearing. In Williams v. SAIF, 99 Or App 367 (November 8, 1989), the court recently held that, under the current version of OAR 438-06-071, Referees are not authorized to dismiss a claimant's hearing request simply because the claimant did not appear at the hearing. The court reasoned that a claimant was entitled to offer the remainder of his/her evidence, even if he/she chose not to testify personally. The court further stated that the choice not to testify did not prevent an insurer from presenting its evidence in defense of the claim.

The relevant language of the version of OAR 438-06-071 cited above and the current version cited by the court in Williams is substantially the same. Both provide that if a party or the party's attorney fail to appear at hearing, then that failure to appear is a waiver of appearance and is grounds for dismissal if the party waiving is the party which requested the hearing.[1]

Here, although claimant did not appear at the hearing, his attorney was present and prepared to proceed with the case on the record. In accordance with the Williams reasoning, claimant's failure to appear and his choice not to testify are not grounds for dismissal under OAR 438-06-071. Accordingly, we conclude that the hearing request should not have been dismissed.

Consequently, we remand to the Hearings Division for a hearing.

ORDER

The Referee's order is reversed and this case is remanded to the Presiding Referee. Since the Referee who initially heard this case is no longer employed by this agency, the Presiding Referee shall assign this case to another Referee, who shall hold further proceedings consistent with this order.

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1. The court, in Williams, cited current OAR 438-06-071. It appears that the rule which was actually applicable in Williams is former OAR 438-06-071, quoted above, because that is the temporary rule which was in effect at the time of the hearing in Williams. See WCB Admin. Order 3-1987 (August 26, 1987). The temporary rule was adopted as a permanent rule, effective January 1, 1988. WCB Admin Order 5-1987 (December 18, 1987). The current version of the rule, which amended the previous version, became effective April 1, 1989. WCB Admin. Order 201989 (March 1, 1989).]

AUBREY L. INGLES, Claimant
Roberts, et al., Defense Attorneys

WCB 87-07313
November 21, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant, pro se, requests review of that portion of Referee Schultz' order that: directed the insurer to pay for chiropractic treatment at the rate of two visits per month after June 11, 1987. In its respondent's brief, the insurer requests review of those portions of the Referee's order that: (1) found chiropractic treatment in excess of two visits per month

reasonable prior to June 11, 1987; (2) assessed a 25 percent penalty on unpaid chiropractic bills submitted prior to June 11, 1987; and (3) assessed a penalty and attorney fee for late denial. In his appellant's brief, claimant has submitted certain medical reports. We treat such material as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). The issues on review are remand, medical services, penalties, and attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

Claimant, 43 years old at hearing, sustained a compensable injury to his neck and right shoulder in February, 1984. The insurer accepted the claim as nondisabling and he has not missed anytime from work. He was treated by Dr. Berovic, chiropractor, and remained under his care at the time of hearing. Dr. Berovic diagnosed cervical-thoracic sprain/strain with myofascitis and cephalgia.

Claimant received chiropractic treatments as often as 13 times per month in 1984. In 1985 his treatment program ranged from 5-6 visits per month to 11 visits per month. From 1986 to August 1987, claimant treated approximately 4 times per month. From August 1987 until the time of the hearing, he was treating 2 times per month.

The insurer stopped paying Dr. Berovic's bills in late 1985 or early 1986, but did not issue a formal denial until August 11, 1987.

ULTIMATE FINDINGS OF FACT

The record has not been improperly, incompletely or otherwise insufficiently developed.

The medical and lay evidence does not establish that claimant's chiropractic treatments in excess of two treatments per month were reasonable or necessary.

Except for those chiropractic services rendered within 60 days of its August 11, 1987 denial, the insurer unreasonably failed to accept or deny claimant's chiropractic treatments within 60 days of its receipt of Dr. Berovic's bills.

CONCLUSIONS OF LAW AND OPINION

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). In order to justify remand, it must be clearly shown that the proferred evidence was not obtainable at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164 (1985).

Here, we are not persuaded that the record concerning the medical services issue has been either improperly, incompletely or otherwise insufficiently developed. We are not persuaded that the documents submitted by claimant were unobtainable with due diligence at the time of hearing. Claimant's brief has attached to it four medical reports. Two of

these reports are already in the record. The documents not already in the record are cumulative in nature to the medical services dispute already documented by similar reports. Accordingly, we conclude that remand is not warranted.

Medical services

The Referee found that claimant had received some benefit from treatment with Dr. Berovic, but that treatment in excess of two times per month had been excessive. We agree with this conclusion; however, we modify the Referee's reasoning with regard to chiropractic treatment in excess of two times per month prior to the August 11, 1987 denial.

The Referee further concluded that because the insurer did not issue a formal denial of the excess treatments until over one year after it ceased paying Dr. Berovic's bills, that the insurer had accepted all billings subsequent to the date of its formal denial. Although this conclusion is relevant in regard to the assessment of penalties and related attorney fees, it does not support a finding that the insurer has accepted such treatment. Nonpayment by the insurer does not equate with acceptance. See Johnson v. Spectra-Physics, 303 Or 49 (1987). Accordingly, the insurer can dispute the reasonableness and necessity of the disputed billings. We now turn to the merits.

Claimant is entitled to all medical services that are reasonable and necessary as a result of the compensable injury. ORS 656.245(1). To prove reasonableness and necessity of the rendered medical services, claimant must establish that at the time the services were rendered, they were likely to be of curative, palliative, preventive or restorative benefit. West v. SAIF, 74 Or App 317, 320-21 (1985).

Dr. Berovic, claimant's treating chiropractor, indicates in his reports that claimant requires at least periodic treatment for his neck and right shoulder. This opinion is supported by the reports of Dr. Segur and Dr. Bussanich who opined that claimant would continue to require at least sporadic care of his compensable condition. Accordingly, we conclude that chiropractic treatment two times per month is reasonable and necessary as a result of claimant's compensable injury.

We do not find, however, that treatment in excess of two times per month is warranted. As noted above, Drs. Berovic, Segur, and Bussanich all opine that claimant needs periodic treatment, but their opinions do not support treatment in excess of the guidelines. In this regard we note that Dr. Simpson opined that the chiropractic treatment then being received by claimant was neither reasonable nor necessary. Further, claimant has continued to work since his compensable injury in 1984 and runs between 2 and 5 miles daily.

We note parenthetically that the Referee's order directed the insurer to pay for chiropractic treatment from June 11, 1987 "onward". The propriety of future chiropractic treatment for claimant's compensable condition is a matter that is not in issue. The Referee's scope of review is limited to claims in denied status. See Thomas v. SAIF, 64 Or App 193 (1983). Therefore, the employer's denial is a denial of medical services claims received as of August 11, 1987, the date of denial. See

Arlene S. Pettit, 40 Van Natta 1610 (1988). Chiropractic treatment after that date, or in the future, was not within the scope of the Referee's review.

Penalties and Attorney Fees

We adopt the Referee's conclusions and reasoning in regard to the penalty and attorney fee issue with the following clarification.

The Referee's order uses June 11, 1987 as a reference point for determining "amounts due" in assessing a penalty. We believe the Referee's order mistakenly refers to June 11, 1987 instead of August 11, 1987, the date of the insurer's formal denial. We consider August 11, 1987 to be the operative date for determination of a penalty.

Further, the "amounts then due" prior to August 11, 1987 include only those amounts found compensable, i.e. treatment two times per month. We agree that a 25 percent penalty should be assessed for late denial, but we assess the penalty on the "amounts due" for two visits per month up to August 11, 1987, and not on all billings not then paid.

ORDER

The Referee's order dated November 3, 1987 is modified. That portion of the order directing the insurer to pay for all chiropractic treatments prior to June 11, 1987 is modified. The insurer is directed to pay for two treatments per month up to August 11, 1987. That portion of the order assessing a penalty for late denial is modified to reflect "amounts due" to be two treatments per month until August 11, 1987. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the insurer to its counsel, not to exceed $1,042.50, is approved.

MARK R. LUTHY, Claimant	WCB 84-05736
Peter E. Baer, Claimant's Attorney	November 21, 1989
Judy Johnson (SAIF), Defense Attorney	Order on Review (Remanding)

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Leahy's order that dismissed his request for hearing on the ground that neither he nor his attorney appeared at the hearing. Claimant contends that both he and his attorney had good cause for their failure to appear and moves for remand to the Referee. We remand the case to the Referee for further evidence taking and reconsideration.

ISSUE

Whether the case should be remanded for a determination of whether claimant should have been granted a postponement of his hearing.

FINDINGS OF FACT

A Notice of Hearing set this case for hearing on October 21, 1987. Both claimant and his attorney were notified of the hearing date. The hearing was set for 9:30 a.m. When neither claimant nor his attorney appeared at that time, the Referee closed the record and dismissed the request for hearing at 9:40 a.m.

After the Referee's order issued, claimant's attorney wrote the Referee to request that he reschedule the matter. There is no response to this request in the record.

CONCLUSIONS OF LAW AND OPINION

Former OAR 438-06-071 became effective September 15, 1987. That rule provides:

> "Failure of a party or the party's representative to appear at the time and place scheduled for a hearing is a waiver of appearance. If the party that fails to appear is the party that requested the hearing, the referee shall issue an order dismissing the request for hearing for failure to appear unless a postponement is granted under 438-060-081[sic]."

Both claimant and his attorney failed to appear at the October 21, 1987 hearing. Former OAR 438-06-071 required the Referee to dismiss claimant's request for hearing unless a postponement was granted. We interpret that rule to mean that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued under former OAR 438-06-071 so long as the Referee retains jurisdiction. In this case, claimant's attorney requested a postponement (rescheduling). The Referee did not rule on that motion.

Based upon the record before us, we cannot determine whether this matter should have been dismissed or postponed. We, therefore, find that the record has been incompletely developed.

ORDER

The Referee's order dated October 29, 1987 is vacated and the case is remanded to Referee Leahy for reconsideration. If the Referee determines that a postponement of the October 21, 1987 hearing should be granted, the Referee shall proceed with a hearing concerning the merits of the claim, as well as addressing the SAIF Corporation's motion to dismiss based on the doctrine of collateral estoppel.

EDWARD A. RANKIN, Claimant
Malagon, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 88-01507
November 21, 1989
Order on Reconsideration

The insurer requests reconsideration of our November 1, 1989 Order on Review that affirmed, with supplementation, a Referee's order setting aside the insurer's partial denial of claimant's chiropractic treatments for his low back condition. In affirming the Referee's order, we did not address the question of the reasonableness and necessity of claimant's current treatment because that issue had not been raised by the insurer's denial, but rather by the insurer during unrecorded closing arguments at hearing. In reaching this decision, we relied on Patricia N. Hall, 40 Van Natta 1873 (1988).

The insurer seeks reconsideration, contending that claimant did not object to the raising of the "reasonable and necessary" issue during closing arguments. Moreover, it implicitly insists that the record concerning the aforementioned issue is

sufficiently developed. Under such circumstances, the insurer asserts that the issue was properly before the Referee.

We have recently held that, where a claimant had the opportunity to object on the record or request a continuance and the record has been sufficiently developed, a Referee or Board may proceed to rule on a causation question raised for the first time at the commencement of a hearing on an aggravation denial. See Dennis C. Reddon, 41 Van Natta 166, 169-70 (1989). We reasoned that, under such circumstances, the claimant waived any right he might otherwise have had to object to the litigation of the issue.

Here, the parties agreed at the beginning of the hearing that the issues pertained to penalties and attorney fees, as well as the insurer's denial that claimant's medical services claim was causally related to his compensable injury. After the closing of the hearing, during unrecorded closing arguments, the insurer raised a reasonable and necessary question concerning claimant's medical services claim.

We consider the time at which this new issue was raised to be a significant distinction from Reddon. We reach this conclusion, particularly because the parties had expressly agreed to the issues before the hearing as recited by the Referee and did not alter their positions during the hearing. Instead, the new issue was only introduced after the hearing had ended, during closing arguments which were unrecorded.

Consequently, after further consideration, we continue to conclude that the question of the reasonableness and necessity of claimant's current medical treatment should not have been addressed by the Referee.

Accordingly, our November 1, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 1, 1989 order. The parties' rights of appeal shall begin to run from the date of this order. A supplemental client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $255.

IT IS SO ORDERED.

KENNETH N. WILLARD, Claimant	WCB 87-09117
Pozzi, et al., Claimant's Attorneys	November 22, 1989
David L. Jorling, Defense Attorney	Order on Review

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Peterson's order which granted claimant an award for permanent total disability. We affirm.

ISSUES

The sole issue is extent of disability. The employer contends that the Referee erred in granting claimant an award for permanent total disability.

FINDINGS OF FACT

Claimant is a 57-year-old man with an eleventh grade

education and a GED. His work experience includes twenty years as a sheet metal worker and approximately ten years working at his job-of-injury as a field inspector for the City of Portland. Claimant has preexisting problems in both knees. In 1981 he compensably injured his right knee. He subsequently developed additional left knee problems as well as right shoulder and right hand problems as sequelae of his compensable injury.

Claimant's knee, shoulder and hand problems confine him to sedentary work, at best. Claimant can lift a maximum of 10 pounds. Claimant has difficulty walking, driving a car, lifting his right arm above shoulder level, kneeling, squatting and crawling. Claimant's knee pain is present approximately 90 percent of the time.

Claimant cooperated with vocational assistance. He spent one year in a training program with on-the-job training as an estimator in the sheet metal field. Although claimant had some difficulty doing the field work which was required by that occupation, he was able to successfully complete the training program. However, since the training program, his knees have worsened to the point that on some days his knee pain is so bad that he can hardly stand. Claimant cannot predict when those days will occur.

Claimant has only made two contacts looking for work since he finished vocational training.

There are no regular and suitable jobs which claimant is capable of obtaining and holding.

CONCLUSIONS

In order to prove entitlement to an award for permanent total disability, a claimant must prove by a preponderance of the evidence that he is "permanently incapacitated from regularly performing work at a gainful and suitable occupation." ORS 656.206(1). This requirement may be satisfied either on the basis of claimant's physical condition alone, or on the basis of claimant's physical condition taken together with the relevant social and vocational factors. Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

We conclude that claimant is not precluded by his physical condition alone from regularly performing work at a gainful and suitable occupation. The medical evidence is that claimant can do sedentary work.

Claimant's testimony, which the Referee found credible, establishes that on some days he is hardly able to stand. Claimant's vocational expert established that all the jobs which the employer's vocational expert identified as suitable for claimant would require him to be able to report to work on a regular schedule. Considering the fact that claimant is hardly able to stand some days, we conclude that he could not be expected to regularly report to work.

We agree with the Referee that claimant meets the "odd lot" doctrine. He is precluded by a combination of his physical impairment and his social and vocational factors from being

regularly employed. Swanson v. Westport Lumber Co., 4 Or App 417 (1971).

We note that the Referee relied on claimant's vocational expert's testimony that claimant's chances of finding suitable employment are slim to none. We do not rely on that statement because the expert applied the definition of suitable employment contained in ORS 656.340(5)(b)(B) rather than the definition contained in ORS 656.206(1)(a). However, the legal error of the vocational expert does not affect her opinion that the jobs which the other expert identified would require claimant to report to work on a regular schedule.

In conclusion, we are persuaded that, but for claimant's compensable injury, claimant would be willing to seek work. Furthermore, because of the magnitude of his compensable physical impairment, we conclude that it would be futile for claimant to search for work. Accordingly, he is excused from further work search under ORS 656.206(3).

ORDER

The Referee's order of January 26, 1988 is affirmed. Claimant's attorney is awarded a reasonable attorney's fee of $650 for services on Board review, to be paid by the self-insured employer.

JACK O. PICHETTE, Claimant — WCB 87-08008
Philip H. Garrow, Claimant's Attorney — November 24, 1989
Richard Barber (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Nichols' order which (1) declined to assess a penalty for an alleged failure to deny a medical services claim; (2) concluded that the claim was not prematurely closed by Determination Order; and (3) awarded 5 percent (16 degrees) unscheduled permanent disability in addition to the 20 percent (64 degrees) unscheduled permanent disability awarded by Determination Order. We reverse.

ISSUES

The first issue is whether a claim was made for a weight loss treatment which would trigger the SAIF Corporation's duty to accept or deny within 60 days.

The second issue is whether claimant has ever been medically stationary.

In the event the Board concludes that claimant is medically stationary, claimant seeks a greater award for unscheduled disability than the 25 percent which has now been awarded.

FINDINGS OF FACT

Claimant compensably injured his low back lifting a tire on September 17, 1985. Claimant was hospitalized by Dr. Horniman for excruciating back pain. At that time, claimant reported his weight at 367 pounds. During a three week stay in the hospital claimant was "starved ruthlessly." He was also given a diet to follow when he left the hospital. His weight was down to 350 pounds by the time he left the hospital.

Diagnostic testing was inconclusive during the hospitalization because claimant's weight made it difficult or impossible. Dr. Neitling took over claimant's care upon discharge from the hospital.

On December 17, 1985, Dr. Neitling wrote to SAIF requesting that it pay for a medically supervised weight program at the Oregon Health Sciences University. Such a program was considered necessary for claimant's recovery. SAIF received the letter on December 31, 1985 but never responded to it in any way.

On May 28, 1986, Dr. Neitling stated that claimant was medically stationary. During the summer of 1986, claimant tried Weight Watchers, but did not really participate because the meetings were primarily attended by women. Dr. Neitling concluded that claimant was medically stationary because his condition was not improving and claimant was not losing weight.

Claimant needs to lose over 100 pounds so that he can undergo physical therapy and enter a work-hardening program. If he goes through these steps, he has a good chance of returning to regular work. Claimant also needs to lose significant weight in order for the physicians to properly investigate and diagnose his condition. It is likely that significant weight loss would materially improve claimant's back condition. Without significant weight loss, claimant's back condition is likely to worsen.

In order to lose weight claimant needs a program in which he is closely supervised both physically and behaviorally.

On September 14, 1987, Dr. Newby referred claimant to Dr. Hilles for an Optifast weight loss program.

CONCLUSIONS

The Referee found the Optifast weight loss program compensable and neither party challenges that portion of her order.

Penalty Issue

The Referee did not read Dr. Neitling's December 17, 1985 letter as a referral to a weight loss program. We disagree.

Dr. Neitling wrote directly to SAIF. He stated that he doubted claimant would recover without a weight loss program. He stated that he had investigated the program at the University and believed it would be ideal for claimant. He reported that claimant could not afford the program on his own. Finally, he requested that SAIF provide claimant with "assistance." ORS 656.005(6) defines a "claim" as "...a written request for compensation from...someone on the worker's behalf...". Compensation includes medical services. (ORS 656.005(8). We conclude that Dr. Neitling filed a claim for medical services which triggered SAIF's duty to accept or deny. The doctor identified the program, described the reason it was related to claimant's treatment for his compensable injury and asked SAIF to pay for it.

Because there was a claim for medical services, SAIF had a duty to accept or deny it within 60 days. Billy J. Eubanks, 35 Van Natta 131 (1983). However, because the medical services had

not been rendered at the time of hearing, there were no "amounts then due" upon which to base a penalty. Lester A. Carmen, 37 Van Natta 1686 (1985). An attorney fee may be awarded, pursuant to ORS 656.382(1), if an insurer unreasonably resists the payment of compensation. LLoyd L. Cripe, 41 Van Natta 1774 (October 23, 1989). We find that SAIF's failure to respond to claimant's claim for medical services was unreasonable and that it had the effect of delaying benefits which were compensable. Therefore, SAIF unreasonably resisted the payment of compensation to claimant. An attorney fee shall be assessed against SAIF.

Premature Closure

The Referee concluded that claimant was medically stationary because claimant had unsuccessfully tried weight loss programs and because there was no evidence that he could not work due to his need to lose weight. We disagree.

Although the treating physician, Dr. Neitling, pronounced claimant medically stationary several times, we are not bound by his use of the magic words. ORS 656.005(17) defines medically stationary to mean "no further material improvement would reasonably be expected from medical treatment or the passage of time." Dr. Neitling's deposition makes it clear that he believes claimant's overweight is, and has been, prolonging his disability, that he should be in a medically supervised weight loss program and that a significant weight loss would probably reduce claimant's disability. Dr. Nash specifically stated that significant weight loss would be likely to allow claimant to return to his regular work. He could not return to regular work at the time of hearing. From this, we conclude that material improvement was reasonably expected from medically supervised weight loss at the time of claim closure. Accordingly, we conclude that claimant was not medically stationary.

Because we find that claimant was not medically stationary, we do not reach the issue of the extent of permanent disability.

ORDER

The Referee's order dated November 19, 1987 is affirmed in part and reversed in part. The Determination Order is set aside and the claim is remanded to the SAIF Corporation for processing consistent with this order. All awards for unscheduled disability are set aside as premature. Claimant's attorney is allowed a reasonable attorney's fee of 25 percent of the increased temporary disability compensation awarded as a result of our conclusion that the claim was prematurely closed, not to exceed $3800. Claimant's attorney is awarded an assessed fee of $500 for services rendered at hearing and on review concerning SAIF's unreasonable claims processing. The Referee's order is affirmed in all other respects.

JEANNIE CLARK, Claimant
Galton, et al., Claimant's Attorneys
Davis, et al., Defense Attorneys
Chelsea Mohnike (SAIF), Defense Attorney

WCB 86-10792, 84-05913 & 87-13771
November 27, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

EBI Companies requests review of that portion of Referee Heitkemper's order that set aside its compensability denial of claimant's industrial injury claim for neck and bilateral thoracic outlet syndrome conditions. In addition, EBI has moved the Board for consideration of additional medical evidence, which was generated after the close of the record. We construe its motion as a request for remand. ORS 656.295(5). On review, the issues are compensability and remand. We reverse in part.

FINDINGS OF FACT

In January, 1981, while employed as a truck driver by the SAIF Corporation's insured, claimant compensably injured her neck. After unsuccessful conservative treatment, diagnostic studies revealed a protruded disc at C5-C6. Consequently, in November, 1981, she underwent a cervical fusion performed by Dr. Misko, her treating neurosurgeon. A Determination Order closed her claim in March, 1982, with an award of 10 percent unscheduled permanent disability. Thereafter, a ruptured disk at C6-C7 was discovered. As a result, her claim was reopened and she underwent further cervical surgery in April, 1983. A Determination Order reclosed her SAIF claim in October, 1983, with an additional award of 40 percent unscheduled permanent disability. Claimant requested a hearing on the issue of extent of unscheduled permanent disability, which was an issue in the proceeding below.

Subsequently, claimant began working as a waitress for EBI's insured, a restaurant. While doing so, she compensably reinjured her neck in June, 1984. She returned to Misko for further conservative care. After Misko diagnosed left thoracic outlet syndrome, EBI issued a partial denial of that condition. Claimant requested a hearing to appeal the denial. A prior Referee found that her left thoracic outlet syndrome condition was not compensable. The Board and the Court of Appeals have affirmed the prior Referee's order. See Jeannie Clark, WCB Case No. 85-10576 (March, 1987), Aff'd mem Clark v. Spinning Wheel, 89 Or App 264 (1988). In July, 1986, a Determination Order closed her EBI claim with no award of permanent disability.

Thereafter, EBI authorized and provided vocational training in dog grooming. On May 7, 1987, while participating in the training program, claimant sustained a slip-and-fall injury. As a result, she was momentarily dazed and felt pain and numbness in her head, neck, and right arm. Although she finished her shift, she telephoned Misko's office the following day. Misko was not available.

In July, 1987, claimant requested EBI to reopen her 1984 neck claim. EBI declined, issuing a timely "aggravation" denial.

Claimant's May, 1987, injury arose out of and in the course of her employment with EBI's insured requiring medical services and resulting in disability. In addition, the injury was a material contributing cause of her existing neck disability.

After EBI requested Board review of the Referee's order, it submitted three medical documents and requested that the Board consider such documents. The documents consist of a radiology report and an operative report, each dated May 17, 1988, and a narrative report from Misko, dated June 10, 1988. The record below was properly, completely, and sufficiently developed.

CONCLUSIONS OF LAW

Remand

We construe claimant's motion for consideration of additional evidence as a request for remand. See ORS 656.295(5). The Board may remand a case to the Referee if it determines that the record has been improperly, incompletely, or otherwise insufficiently developed. Id. Here, the additional evidence that EBI wishes the Board to consider, consists of x-ray findings, an operative report of an angiogram of the subclavian vessels, and a narrative report from Misko. After reviewing such documents, we are not persuaded that the record below was improperly, incompletely, or otherwise insufficiently developed. Id.

Accordingly, we decline to grant EBI's motion to remand this case for the admission of additional evidence.

Compensability

The Referee analyzed this case under the aggravation test set forth in Smith v. SAIF, 302 Or 109 (1986), and concluded that claimant had proven a worsening of her "underlying condition." In so doing, the Referee did not specify what the "underlying condition" was or whether it included both claimant's neck and bilateral thoracic outlet syndrome conditions. Further, the Referee made no distinction between claimant's left and right thoracic outlet syndrome conditions. (The left thoracic outlet syndrome condition has been held not compensable by the Court of Appeals. See Clark v. Spinning Wheel, supra.).

Although we disagree with the Referee's analysis, we agree, in part, with his conclusion that EBI's denial should be set aside.

The parties and the Referee have variously framed the instant issue as one of "aggravation," "compensability," and/or "new injury." We conclude that, like the case of Fenton v. SAIF, 87 Or App 78 (1987), the case actually presents an issue of the compensability of the consequences of claimant's May 7, 1987 incident. See also Firkus v. Alder Cr. Lbr., 48 Or App 251 (1980), rev den 290 Or 302 (1981) (Injury incurred while engaged in a vocational training program is a compensable consequence of the original injury).

Before turning to the merits of the compensability question, however, we observe that the settled law of this case is that claimant's left thoracic outlet syndrome condition is not compensable. EBI's partial denial of that condition was upheld by a prior Referee's order, which has been affirmed by both the Board and the Court of appeals. Clark v. Spinning Wheel, supra. Moreover, despite the Referee's failure to indicate that the left thoracic outlet syndrome condition was outside the purview of this case, the parties themselves seemed to indicate such. (Tr. 46).

Additionally, we find no potentially compensable worsening of that underlying preexisting condition. Dr. Misko indicated that claimant's May 7, 1987 incident "aggravated" claimant's preexisting left thoracic outlet syndrome. Whether he meant that it worsened claimant's symptoms and/or worsened the underlying condition is not clear. Accordingly, we confine our compensability analysis to claimant's right thoracic outlet syndrome and neck conditions.

Claimant fell while participating in a vocational rehabilitation program authorized and provided by EBI. Inasmuch as her fall was incurred as a result of participating in an approved training program, which was made available as a result of the compensable June, 1984 neck injury, we conclude that her May, 1987 injury was a compensable consequence of the June, 1984 injury. Fenton v. SAIF, supra; Wood v. SAIF, 30 Or App 1103 (1977), rev den 282 Or 189 (1978).

Our inquiry does not end, however. The parties dispute whether the second injury -- the May, 1987, fall -- materially contributed to the causation or worsening of claimant's right thoracic outlet syndrome condition. The medical experts are divided in their opinions as to the proper diagnosis and etiology of claimant's current conditions. In October, 1987, Misko reported, inter alia:

> "I would state that [claimant's] fall while working in dog grooming caused a cervical strain superimposed upon a previous cervical injury and surgery and also aggravated her thoracic outlet syndrome on the right. The thoracic outlet syndrome on the left was previously present and was caused by her previous cervical condition. This was certainly aggravated by her fall. The thoracic outlet syndrome on the right was not present prior to her fall and was a direct consequence of her fall and also the cervical injury resulting from that * * *. I think she is entitled to another 25 percent permanent partial disability rating because of her bilateral untreated thoracic outlet syndrome and because of an increased injury to her neck in the form of soft tissue injury superimposed on the previous injury. Thoracic outlet syndrome is permanent without surgical treatment."

Dr. Porter, a thoracic outlet syndrome specialist, testified at the hearing. According to Porter, there are only three types of recognized thoracic outlet syndromes: (1) arterial; (2) venous; and (3) neurogenic. (Tr. 44). Porter testified that claimant lacks the necessary objective clinical findings which would lead to a diagnosis of thoracic outlet syndrome. Moreover, Porter further testified that the only type of physical trauma that results in thoracic outlet syndrome is that which is associated with a bony rib or collarbone fracture. (Tr. 54). Claimant has none. Porter did concede, however, that the May, 1987 fall was consistent with a diagnosis of "neck sprain and/or strain." (Tr. 60).

We must choose the correct medical hypothesis. McClendon v. Nabisco Brands, Inc., 77 Or App 418 (1986). After weighing the evidence, we are persuaded by the opinion of Porter over that of Misko. Porter is an expert on the topic of thoracic outlet syndrome and offered a thorough and logical explanation of his opinion. Accordingly, we conclude that claimant's compensable May, 1987 injury did not result in a condition of right thoracic outlet syndrome.

Regarding claimant's neck sprain/strain condition, however, we conclude that the May, 1987 injury materially contributed to claimant's existing neck disability. See Harris v. Albertson's Inc., 65 Or App 254, 257 (1983). Misko and Porter appear to agree on that point; i.e., that the fall caused a neck strain. (Tr. 60). We, therefore, conclude that the May, 1987 fall resulted in a compensable neck sprain/strain injury.

ORDER

The Referee's order dated March 18, 1988, as reconsidered on April 22, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that set aside EBI's denial with respect to both the left and right thoracic outlet syndrome condition, is reversed. The aforementioned portion of EBI's denials reinstated and upheld. With respect to the neck strain condition, that portion of the order that set aside EBI's denial, is affirmed. Claimant's attorney is awarded an assessed fee of $400, to be paid by EBI . The Board approves a client-paid fee, payable from EBI to its attorney, not to exceed $1,250. The remainder of the Referee's order is affirmed.

PATRICIA J. LaLONDE, Claimant	WCB 86-13914
Malagon, et al., Claimant's Attorneys	November 27, 1989
William Blitz (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of those portions of Referee Emerson's order that: (1) assessed a penalty for failure to deny claimant's request for surgery in timely fashion; and (2) assessed an attorney fee of $3,500 in connection with setting aside SAIF's denial of surgery and setting aside two Determination Orders as premature. We affirm the penalty but reduce the assessed attorney fee. Claimant also requests a fee payable by SAIF for services rendered on Board review. We deny that request.

ISSUES

1. Penalty for untimely denial of claimant's request for surgery on his right wrist.

2. The amount of the attorney fee assessed by the Referee.

3. Attorney fee for services rendered on Board review.

FINDINGS OF FACT

Claimant developed symptoms in her right wrist, hand and arm in March 1986. The condition was diagnosed as flexor tenosynovitis and carpal tunnel syndrome. SAIF accepted

claimant's claim for the condition on March 14, 1986. Dr. Butters, an orthopedic surgeon, performed a surgical release of claimant's right carpal tunnel on November 19, 1986.

In early 1987, claimant began to complain of a painful mass on the back of her right hand. One physician noted that claimant's history included a ganglion of the right wrist which had been surgically removed in 1975. (Ex. S-1). Dr. Butters diagnosed the mass as dorsal tenosynovitis. (Ex. U). Another physician described the mass as a "bony enlargement." (Ex. 1C-1).

Claimant's right wrist claim was closed by Determination Order dated August 4, 1987. Claimant requested reconsideration of the order and a second Determination Order issued on August 25, 1987 which affirmed the first.

By letter dated September 2, 1987, Dr. Butters requested authorization from SAIF to perform surgery on the mass on the back of claimant's hand. SAIF received this letter on September 22, 1987.

On December 16, 1987, claimant was examined by Dr. Nathan, a hand specialist. In a report dated December 29, 1987, Dr. Nathan noted the mass on the back of claimant's right hand and opined that it was either a ganglion or tenosynovitis. Regardless of which diagnosis was correct, Nathan opined that the mass was unrelated to claimant's employment or to the treatment she had received for her compensable carpal tunnel syndrome.

SAIF received Dr. Nathan's report on January 4, 1988 and on the same date issued a denial of the surgery requested by Dr. Butters on the ground that the mass on the back of claimant's right hand was unrelated to the compensable claim. Claimant requested a hearing on the denial which was consolidated with other hearing requests.

At the beginning of the hearing, claimant identified a number of issues including SAIF's denial of surgery and premature claim closure. Claimant's attorney participated in the hearing, in a post-hearing deposition of Dr. Butters and in closing arguments by telephone. He submitted a statement of services to the Referee which reflected all of the issues raised by claimant at the hearing, but gave no indication of the amount of attorney or paralegal time spent on each issue.

The Referee set aside SAIF's denial of surgery, set aside as premature the Determination Orders closing claimant's claim, assessed a penalty and $500 attorney fee for untimely denial and assessed a fee of $3,500 in connection with setting aside the surgery denial and the two Determination Orders. The other issues raised by claimant were either moot or decided against him.

SAIF filed a request for Board review and raised as issues the penalty for its failure to deny the request for surgery in a timely manner and the amount of the assessed attorney fee. Claimant's attorney filed a brief which responds to the issues raised by SAIF. The attorney also submitted a statement of services rendered on Board review and requests a fee payable by SAIF for those services.

FINDINGS OF ULTIMATE FACT

1. SAIF's failure to deny claimant's request for surgery within 60 days was unreasonable.

2. The attorney fee assessed by the Referee in connection with setting aside the denial of surgery was excessive.

3. Claimant's attorney rendered no services on Board review which relate to claimant's entitlement to receive compensation or the amount of that compensation.

CONCLUSIONS OF LAW

1. Penalty for Untimely Denial

A carrier which unreasonably delays acceptance or denial of a claim is liable for a penalty of up to 25 percent of compensation "then due". ORS 656.262(10). Delay in acceptance or denial of a request for prospective medical services beyond 60 days after notice or knowledge of the request is unreasonable unless the record reflects a reasonable justification for the delay. See ORS 656.262(6) & (10); Billy J. Eubanks, 35 Van Natta 131, 135 (1983).

SAIF received Dr. Butters' request for authorization for surgery on September 22, 1987. It should have accepted or denied the request within 60 days. It did not issue its denial until January 4, 1988, 104 days after receiving the request.

SAIF argues that its delay in issuing the denial was due to the fact that it was awaiting the report of Dr. Nathan. Such a justification might be reasonable if the record contained evidence establishing that a consultation with Dr. Nathan or another qualified physician could not have been scheduled in time to meet the 60-day deadline. The record, however, contains no such evidence. We agree with the Referee, therefore, that SAIF's failure to deny the request for surgery within 60 days was unreasonable and affirm the penalty and associated attorney fee assessed by the Referee.

2. The Attorney Fee Assessed by the Referee in Connection With Setting Aside the Denial of Surgery and the Determination Orders

The Referee assessed a fee of $3,500 against SAIF in connection with setting aside the surgery denial and two Determination Orders. SAIF contends that this fee is excessive because much of the work performed by claimant's attorneys and reflected in the statement of services related to issues on which claimant did not prevail, or issues for which there is no statutory authority for a carrier-paid fee or to the penalty issue for which a separate fee of $500 was assessed. Claimant counters that under Greenslitt v. City of Lake Oswego, 305 Or 350 (1988) the Board is without jurisdiction to review the amount of the fee because SAIF did not seek review of the merits of the surgery denial. We address claimant's jurisdictional argument first.

In Greenslitt v. City of Lake Oswego, supra, the Court attempted to define the jurisdictional boundary between the Board and the circuit courts in disputes involving attorney fees assessed by referees under ORS 656.386(1). The Referee's order in

that case set aside a denial of an occupational disease claim and assessed a carrier-paid attorney fee under ORS 656.386(1). The insurer requested Board review of the order and argued the issues of compensability and the amount of the attorney fee. Under those circumstances, the Court held that jurisdiction of the attorney fee issue was with the Board rather than the Circuit Court. Id. at 536. It noted that an attorney fee award under ORS 656.386(1) is effective only after the claimant "prevails finally" on the merits of his claim. Id. at 534-35. Because an appeal on the merits prevents the order from becoming final, the Court concluded that the circuit court procedure prescribed under ORS 656.386(1) was inapplicable and that the Board had authority to review the fee pursuant to ORS 656.382(2). Id. at 535-36 & n.4. In such cases, the Court stated that "[t]he statutes do not contemplate inefficient use of resources in which the merits of the dispute and the issue of attorney fees are reviewable by different forums at the same time." Id. at 536.

We conclude that we have jurisdiction. The basis for jurisdiction in this case is the fact that the attorney fee assessed by the Referee under ORS 656.386(1) was not the only aspect of the Referee's order which was expressly raised on Board review. SAIF also raised and argued the issue of the penalty assessed under ORS 656.262(10). That issue must be addressed by the Board; there is no statutory authority for circuit court review of such matters. See Greenslitt v. City of Lake Oswego, supra, 305 Or at 536-36; Betty L. Evans, 41 Van Natta 21 (1989). Because the case came before the Board on the merits of another issue, claimant could not finally prevail without Board review. The law does not contemplate that the Board review the penalty issue but require a separate circuit court proceeding for review of the attorney fee assessed under ORS 656.386(1). Id. at 536.

We turn to the merits of SAIF's arguments regarding the fee. SAIF contends that claimant's attorney was not entitled to a fee under ORS 656.386(1) on a number of issues for which claimant's attorneys rendered services. We agree.

A Referee may assess a fee under ORS 656.386(1) only when the claimant has prevailed in a "rejected case." A "rejected case" is a case in which entitlement to receive compensation, as opposed to the amount of compensation or extent of disability, is at issue. Short v. SAIF, 305 Or 541, 545-46 (1988). When a single case involves issues of both types, the claimant's attorney is entitled to a fee under ORS 656.386(1) for services rendered in connection with issues of the first type, but not for those rendered in connection with issues of the second type. See Shoulders v. SAIF, 300 Or 606, 610 (1986); Alson R. Valentic, 38 Van Natta 1422, 1423 (1986).

Claimant's entitlement to receive compensation was not at risk on the issues of premature claim closures. The Referee, however, awarded an assessed fee, not only for services related to setting aside SAIF's denial, but for setting aside the Determination Orders as premature. Claimant's attorney was not entitled to an insurer-paid fee under ORS 656.386(1) for services rendered in connection with premature claim closure.

Claimant's statement of services gives no indication of how much time was spent on each issue. Based upon our review of the record in this case, we conclude that the issue of SAIF's surgery denial was the primary issue at the hearing level.

Considering that fact along with the factors enumerated in OAR 438-15-010(5), we conclude that a $2500 fee is appropriate.

Attorney Fee for Services Rendered on Board Review

A carrier-paid fee may be assessed under ORS 656.382(2) when a carrier initiates a request for Board review and the Board determines that "the compensation awarded to the claimant should not be disallowed or reduced." SAIF did not raise issues relating to claimant's entitlement to receive compensation or the amount of that compensation and claimant's attorney did not render any services on Board review in connection with such issues. Neither the penalty awarded by the Referee nor the attorney fee assessed against the insurer are "compensation" for these purposes. Dotson v. Bohemia Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986); Saxton v. SAIF, 80 Or App 631 (1986). Under these circumstances, claimant's attorney is not entitled to a carrier-paid fee under ORS 656.382(2). See Dotson v. Bohemia, Inc., supra.

ORDER

The Referee's order dated March 30, 1988, as modified and republished by the Order on Reconsideration dated April 15, 1988, is modified in part. The attorney fee assessed by the Referee under ORS 656.386(1) in connection with the SAIF Corporation's denial of surgery is reduced from $3,500 to $2,500. The remainder of the Referee's order is affirmed.

ANN PLEMON, Claimant	WCB 86-05665 & 88-00276
Callahan, et al., Claimant's Attorneys	November 27, 1989
Beers, et al., Defense Attorneys	Order on Review
Nelson, et al., Defense Attorneys	

Reviewed by Board Members Howell and Speer.

EBI Companies requests review of those portions of Referee Hettle's order which: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for his current back condition; (2) set aside EBI's denial of claimant's current chiropractic treatments, as well as EBI's continued responsibility for claimant's back condition; and (3) awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order had awarded no permanent disability. The issues on review are medical services, responsibility and extent of disability.

The Board affirms and adopts the order of the Referee with the following supplementation. EBI's December 10, 1987 denial of chiropractic treatment denied only future treatment. Specifically, it stated: "In connection with this denial, EBI has paid all bills for treatment received up to this date." As such, EBI's denial was a prospective denial of medical services which is invalid. See Evanite Fiber Corp. v. Striplin, 99 Or App 353 (November 8, 1989). The record reflects no denied claims (billings) for medical services after December 10, 1987.

Accordingly, we conclude that the setting aside of EBI's denial was proper because the denial was invalid.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on

Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated May 5, 1988, is affirmed.

CECIL B. SMITH, Claimant	WCB 87-04162
Sellers & Jacobs, Claimant's Attorneys	November 27, 1989
Chelsea Mohnike (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Leahy's order which: (1) upheld the SAIF Corporation's partial denial of headaches and low back pain; (2) upheld its subsequent partial denial of headaches and seizures; and (3) declined to assess penalties and associated attorney fees for alleged unreasonable claims processing. We affirm.

ISSUES

1) Whether SAIF's April 8, 1987 denial of headaches and seizures is an improper preclosure denial. See Roller v. Weyerhaeuser, 67 Or App 583 (1984).

2) Whether that portion of SAIF's January 16, 1987 denial which denied claimant's low back pain is an improper "backup" denial giving rise to entitlement to a penalty and related attorney fee. See Bauman v. SAIF, 295 Or 788 (1988).

3) Whether SAIF's failure to forward certain medical reports to the Evaluation Division after requesting claim closure amounts to unreasonable claims processing.

4) Whether SAIF's December 18, 1986 Notice of Closure, which was rescinded the following day, was an unreasonable delay or refusal to pay compensation warranting imposition of a penalty and related attorney fee.

FINDINGS OF FACT

The Board adopts the Referee's factual findings through the first paragraph on page four of his order. In addition, the Board makes the following findings.

At hearing, claimant orally withdrew his hearing request with regard to that portion of SAIF's April 8, 1987 denial which denied the compensability of seizures.

Claimant did not begin reporting neck pain and headaches until two months after his compensable injury.

Claimant's headache condition is separable from his compensable low back strain.

CONCLUSIONS OF LAW AND OPINION

Preclosure Partial Denial of Headaches

Claimant argues that SAIF's denial amounted to an attempt to terminate future responsibility for a compensable condition before the extent of his disability had been determined. The Court of Appeals in Roller v. Weyerhaeuser, 67 Or App 583, 586 (1984), held that an employer could not issue such a denial because "that procedure is tantamount to authorizing it to bypass a hearing on the extent of a claimant's disability and could preempt the resolution of an issue that is involved in determining the extent of disability."

That is not the situation in this case, however. Claimant's original injury was a low back injury. Claimant's headaches are sufficiently separable from his accepted low back condition to be the subject of a preclosure partial denial. See Aquillon v. CNA Insurance, 60 Or App 231, rev den 294 Or 460 (1983).

Moreover, substantively, claimant has not proven that his headaches are materially related to the accepted back claim so as to make them compensable. The medical evidence does not make that connection. Nor does claimant's testimony, which the Referee found so vague as to be unreliable. Further, we decline to infer causation from mere chronological sequence, particularly where claimant's seizure condition provides an alternative cause for claimant's headaches. Bradshaw v. SAIF, 69 Or App 587, 589-90 (1984). Claimant has failed to establish, by a preponderance of the evidence, the necessary causal connection. Thus, we conclude that his headaches are not compensable.

We conclude that the Referee properly upheld SAIF's April 8, 1987 partial denial of headaches.

Penalties and Attorney Fees

Claimant contends that he is entitled to penalties and related attorney fees for improper claims processing. The first basis for the alleged improper processing is SAIF's failure to provide the Evaluation Division with medical reports received subsequent to its submission of the claim to the Evaluation Division for claim closure.

Former OAR 436-30-030 states that the insurer must submit "all medical reports and reports of vocational rehabilitation counselors and agencies accumulated during the life of a claim." SAIF had submitted all the reports it had up to the time of the Evaluation request. The four reports that claimant argues should have been submitted to Evaluation were received by SAIF after its request for closure. Those four reports refer to claimant's noncompensable seizure condition rather than to his compensable back condition. They could not, therefore, have had any bearing upon the determination of whether claimant was medically stationary or the extent of his injury-related disability. We find no basis for penalties in this instance.

Claimant next contends that he is entitled to penalties and related attorney fees for an allegedly improper "back-up" denial issued by SAIF on January 16, 1987. A "back-up" denial is

a subsequent denial, by an insurer, of a previously accepted condition. Such denials are improper absent proof of fraud, misrepresentation, or other illegal activity. Bauman v. SAIF, 295 Or 788 (1983).

It is apparent, however, that pursuant to its January 10, 1987 denial, SAIF was not retroactively denying claimant's original thoracolumbar strain. Rather, SAIF denied the compensability of claimant's current condition of low back pain. Clyde C. Wyatt, 36 Van Natta 1067 (1984); William J. Anderson, 38 Van Natta 1489 (1986). In light of the fact that SAIF did not attempt to impermissibly deny claimant's accepted low back claim, we conclude that claimant is not entitled to penalties or related attorney fees.

Claimant further contends that he is entitled to penalties and related attorney fees because of SAIF's alleged misuse of the self-closure provisions in ORS 656.268(3).

Claimant's claim was closed by Determination Order on November 28, 1986. Thereafter, on December 18, a SAIF trainee issued a Notice of Closure. The notice was in error as the claim was already closed at the time. The Notice of Closure was rescinded the following day. The notice served no purpose and had no effect on the previously closed claim. Because the Determination Order, rather that the Notice of Closure closed the claim, ORS 656.268(3)(F) does not apply. Penalties and related attorney fees are awarded only as expressly authorized by statute. No statute provides for assessment of a penalty or related attorney fees under these circumstances.

ORDER

The Referee's order dated November 20, 1987 is affirmed.

PEDRO G. ALCALA, Claimant
Michael B. Dye, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 87-13384
November 28, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee M. Johnson's order which upheld the insurer's denial of medical services. The issue on review is whether the insurer is responsible for claimant's current need for medical treatment. We affirm.

FINDINGS OF FACT

Claimant compensably injured his back in a motor vehicle accident in September 1983. Claimant received an award for 5 percent unscheduled disability by stipulation. In March 1986 claimant injured his back while working for a Washington employer. By Order on Review dated December 11, 1987, it became the law of the case that claimant's condition at that time was the responsibility of the Washington insurer, not the Oregon insurer.

CONCLUSIONS AND OPINION

The Referee found that claimant's condition had returned

to the same level it had been at before the Washington injury. We disagree with that finding.

On June 15, 1987, Dr. Romanick, claimant's treating chiropractor, wrote the Washington Department of Labor and Industries stating that claimant had permanent impairment due to the Washington injury. The next day he wrote the Oregon insurer stating that claimant had returned to the same condition as he had been before the Washington injury. He requested that the Oregon insurer, therefore, pay for continuing palliative care. The chiropractor wrote to claimant's attorney on November 25, 1987 stating that he had never meant to say that claimant had impairment due to the Washington injury. He stated that all claimant's current need for treatment was due to the Oregon injury. The chiropractor's explanation for his shifts in opinion is not persuasive.

On the other hand, Dr. Bolin, another chiropractor, evaluated claimant's records in August 1987. He had seen claimant three times before. He reasoned that if claimant indeed injured his back in Washington, he could not understand how that injury would resolve when the earlier had not.

We find Dr. Bolin more persuasive than Dr. Romanick. Accordingly, we conclude that claimant has failed to prove by a preponderance of the evidence that his current need for treatment is due to the Oregon injury.

Because of this finding, we need not decide the question of whether the effect of the earlier Order on Review is to forever bar claimant from receiving benefits from the Oregon insurer as a result of the compensable injury in Washington.

ORDER

The Referee's order, dated July 14, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $1,457.50.

GRACIA A. CARTER, Claimant	WCB 87-17682
Pozzi, et al., Claimant's Attorneys	November 28, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Smith's order that granted claimant an award of permanent total disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant, a 53 year old former sales manager, has a history of chronic low back pain. In 1972, she injured her low back and right leg in a nonindustrial slip-and-fall accident. As a result, she suffered fractures of the transverse processes at L3-4. She demonstrated hysterical personality features in recovering from the 1972 injury. Although she performed her regular salesperson duties between 1972 and 1979, she was regularly hospitalized during that seven-year period for flare-ups of low back pain.

In March, 1979, claimant sustained a compensable

lumbosacral strain resulting in a brief period of hospitalization. She treated conservatively with Dr. Borman, M.D. Although she returned to regular work within two weeks, she continued to experience low back pain. Thereafter, her treatment was administered by Dr. Gambee, M.D., her family physician. In December, 1979, she was terminated from work by the insured. She became bitter about the termination and alleged that the insured had not properly reimbursed her for all of her travel expenses.

Claimant's recovery from the March, 1979, injury began to become increasingly affected by her psychological difficulties. She was examined by Dr. Parvaresh, a psychiatrist, in December, 1979, Dr. Larsen, a psychologist, in July, 1982, and Dr. Voiss, a psychiatrist, in January, 1983. The insurer denied the compensability of her psychological condition and claimant requested a hearing. In an Opinion and Order, dated August, 1984, Referee Neal concluded that claimant had proven a compensable psychological condition. The Board affirmed Referee's Neal's order. See Gracia A. Carter, 36 Van Natta 1604 (1984).

Thereafter, the mental health experts reexamined claimant on several occasions. The consensus of the experts was that claimant suffered from a dysthymic disorder, which greatly affected her outlook and perception of her physical abilities. As a result, she was admitted to a pain clinic program in March, 1986. Although vocational retraining was recommended by the pain center staff, claimant was not interested in retraining because she perceived herself as not employable.

In March, 1987, the Orthopaedic Consultants ("Consultants") examined claimant. At that time, claimant's physical abilities -- as affected by her psychological condition -- precluded her from all but sedentary or light occupations.

At the time of the hearing, claimant was still not employed. She performed routine domestic chores, but tried to avoid almost all lifting. She regularly drove a car to-and-from the grocery store. In August, 1987, she drove with four girl friends to Reno, Nevada. They stopped every two hours to rest and stretch. Claimant gambled, watched shows, and did some sightseeing. In January, 1988, she traveled by bus to Medford, Oregon -- a seven hour one-way trip. A friend drove her back. She has not looked for work in over a year. She has not seen a doctor since her evaluation by the Consultants in March, 1987.

Claimant has mild permanent physical impairment and, additionally, mild permanent psychological impairment due to the March, 1979, compensable injury.

Claimant is permanently incapacitated from regularly performing gainful and suitable employment due to the March, 1979, compensable injury and its psychological sequelae. Given the combination of both her compensable physical and psychological conditions, it would be futile for her to seek work.

CONCLUSIONS OF LAW

We adopt the "opinion" section of the Referee's order with the following supplementation.

It is the law of the case that claimant's psychological

condition as it existed in March, 1984, was compensable. We find no persuasive evidence that there have been any intervening events since the record was developed before Referee Neal in March, 1984 which would sever the causal connection between the psychological condition and the compensable injury. Therefore, we conclude that claimant's current psychological condition remains causally related to the March, 1979, compensable injury.

Given our above findings, we conclude that the combined effect of both claimant's compensable low back and pyschological conditions make it "futile," see Brech v. SAIF, 72 Or App 388 (1985), for her to presently seek work. Her lack of motivation to return to work, must be considered in the light of her combined compensable physical and pyschological disabilities. George M. Turner, 37 Van Natta 531 (1985). Accordingly, we conclude that, on this record, ORS 656.206(3) does not bar an award of permanent total disability.

ORDER

The Referee's order, dated March 15, 1988, is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $1,000, to be paid by the insurer. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,445.

FLOYD A. CROUCH, Claimant	WCB 88-02940
William H. Skalak, Claimant's Attorney	November 28, 1989
Scheminske & Lyons, Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Leahy's order which upheld the insurer's denial of his medical services claim for a heart condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a left shoulder injury in November 1985. It was diagnosed as an anterior dislocation. In July 1986, his left shoulder again dislocated and was put back into place in the emergency room. He continued to be symptomatic and in February 1987 an arthroscopic evaluation was performed. At that time, the physicians recommended two alternatives: physical therapy with avoidance of any movements that would cause subluxation or dislocation or reconstructive surgery on the shoulder. In April 1987, claimant was given a limited work release which recommended that he avoid any motions which caused subluxation or dislocation. Claimant continued to suffer dislocations.

In October 1987 claimant was referred to Dr. Switlyk, an orthopedic surgeon. Dr. Switlyk recommended reconstructive surgery on the left shoulder, but indicated that claimant should undergo a cardiac exam prior to performing the surgery. In late November 1987, claimant underwent a cardiac examination. During the course of an aortic catheterization, claimant developed a pericardial tamponade which required emergency surgery. While performing surgery to relieve the tamponade, the physician found it appropriate to also perform an aortic valve replacement

procedure. Claimant's discharge summary indicated that he had progressive aortic stenosis.

In December 1987, Dr. Switlyk reported that claimant was not an acceptable candidate for surgery due to his recent heart surgery. In January 1988, the employer denied responsibility for the heart surgery. In March 1988, claimant was doing reasonably well following the heart surgery and Dr. Switlyk planned on performing the shoulder surgery as soon as approved by the heart specialist.

FINDINGS OF ULTIMATE FACT

Claimant's heart surgery and its sequelae were a necessary prelude to surgery on his compensable left shoulder condition

CONCLUSIONS OF LAW

The Referee concluded that claimant's heart surgery was not a necessary prelude to the proposed left shoulder surgery and found it not compensable. We disagree.

This question was before the Supreme Court in Williams v. Gates, McDonald & Co., 300 Or 278 (1985). In Williams, supra, it was necessary for the claimant to undergo a right carotid endarterectomy, before surgery could be performed on her compensable back condition. The Court found the carotid artery surgery and its sequelae compensable on the basis that it was a necessary prelude to the proposed back surgery. Id. at 281. The Court noted that there was no evidence that claimant would have submitted to the carotid artery procedure had it not been required prior to performing back surgery. Id. In addition, the Court noted that both operations were required for claimant's total medical treatment and that such treatment was necessitated by the industrial injury. Id.

Similarly, in the present case, claimant underwent the cardiac examination as a prelude to his proposed shoulder surgery. During the course of that examination, he developed a tamponade which necessitated emergency surgery, including the aortic valve replacement procedure. There is no persuasive evidence to suggest that claimant would have submitted to the heart procedure, had it not been a necessary prelude to the proposed shoulder surgery. Finally, Dr. Switlyk reported that the shoulder surgery was still being planned as soon as claimant recovered from the effects of the heart surgery.

We find no meaningful distinction between Williams, supra, and the instant case. Accordingly, the heart procedure and its sequelae, are compensable.

ORDER

The Referee's order, dated May 17, 1988, is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on Board review, concerning this issue, claimant's counsel is awarded a reasonable carrier-paid fee of $2,000. A client-paid fee, not to exceed $1,266, is approved.

MARK S. LESOWSKE, Claimant
Frank J. Susak, Claimant's Attorney
Stafford J. Hazelett, Defense Attorney

WCB 88-01769
November 28, 1989
Order on Review (Remanding)

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Leahy's order which dismissed his request for hearing for failure to appear. On review, the issue is whether the Referee should have dismissed the request for hearing. We remand.

FINDINGS OF FACT

On February 5, 1988, claimant requested a hearing to protest a denial from the insurer. The request was received by the Workers' Compensation Board on February 8, 1988. On February 16, 1988, the Board sent to claimant's address, as well as to claimant's counsel, a Notice of Hearing notifying them that the Hearing was set for April 20, 1988.

Apparently, no formal hearing was convened, but claimant's counsel appeared for the hearing. Claimant did not appear. On April 27, 1988, the Referee issued an order which stated:

> "The Referee was advised that the claimant has not kept in touch with his counsel. His present whereabouts are unknown. The file reflects that the Notice of Hearing mailed to claimant at this last known file address has not been returned by the Post Office Department undelivered. It is therefore presumed that he had notice of this hearing."

The order gave claimant 30 days in which to show cause for his failure to appear. On April 28, 1988, claimant's counsel submitted a motion for reinstatement on the basis of claimant's affidavit which indicated that he had been hospitalized for two weeks prior to the hearing, had been discharged on the date of hearing and due to the hospitalization, had forgotten about the hearing and would have been unable to attend in any event. The insurer did not respond to the motion or to the affidavit.

On May 16, 1988, the Referee issued an Order of Dismissal, indicating that claimant's affidavit was not sufficient to support reinstatement.

Claimant requested review.

CONCLUSIONS

At the time of hearing <u>former</u> OAR 438-06-071 was in effect. It stated:

> "Failure of a party or the party's representative to appear at the time and place scheduled for a hearing is a waiver of appearance. If the party that fails to appear is the party that requested the hearing, the referee shall issue an order

> dismissing the request for hearing for failure to appear unless a postponement is granted under OAR 438-06-081."

Former OAR 438-06-081 prohibited postponements except upon a finding of extraordinary circumstances beyond the control of the party requesting the postponement.

We conclude that the Referee was incorrect in dismissing the hearing request based on claimant's failure to appear at the hearing. In Williams v. SAIF, 99 Or App 367 (November 8, 1989), the court recently held that, under the current version of OAR 438-06-071, Referees are not authorized to dismiss a claimant's hearing request simply because the claimant did not appear at the hearing. The court reasoned that a claimant was entitled to offer the remainder of his/her evidence, even if he/she chose not to testify personally. The court further stated that the choice not to testify did not prevent an insurer from presenting its evidence in defense of the claim.

The relevant language of the version of OAR 438-06-071 cited above and the current version cited by the court in Williams is substantially the same. Both provide that if a party or the party's attorney fail to appear at hearing, then that failure to appear is a waiver of appearance and is grounds for dismissal if the party waiving is the party which requested the hearing.[1]

Here, although claimant did not appear at the hearing, his attorney was present. In accordance with the Williams reasoning, claimant's failure to appear is not grounds for dismissal under OAR 438-06-071. Accordingly, we conclude that the hearing request should not have been dismissed.

Furthermore, we conclude that under the circumstances of this case, claimant has not waived his right to testify. We have recently held that under the rule applicable to this case,

> "a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued...so long as the Referee retains jurisdiction." Mark R. Luthy, 41 Van Natta 2132 (November 21, 1989).

Here, the Referee correctly treated claimant's motion and affidavit as a motion for postponement. He apparently found the affidavit insufficient to establish extraordinary circumstances beyond claimant's control sufficient to justify a postponement. We disagree.

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[1] The court, in Williams, cited current OAR 438-06-071. It appears that the rule which was actually applicable in Williams is former OAR 438-06-071, quoted above, because that is the temporary rule which was in effect at the time of the hearing in Williams. See WCB Admin. Order 3-1987 (August 26, 1987). The temporary rule was adopted as a permanent rule, effective January 1, 1988. WCB Admin. Order 5-1987 (December 18, 1987). The current version of the rule, which amended the previous version, became effective April 1, 1989. WCB Admin. Order 2-1989 (March 1, 1989).

There is sufficient evidence on this record to make a finding under former OAR 438-06-081 that there were extraordinary circumstances beyond claimant's control which would justify a postponement. By rule, the insurer had ten days in which to respond to claimant's motion and affidavit. It did not do so. Accordingly, we deem claimant's affidavit to establish its allegations as uncontroverted facts. Claimant's affidavit establishes that claimant was in the hospital for two weeks before the hearing and was not discharged until the day of the hearing. It further establishes that even if claimant had not forgotten about the hearing, he could not have attended the hearing. We conclude that these uncontroverted facts are sufficient to establish that there were extraordinary circumstances beyond claimant's control which would justify a postponement. Consequently, by failing to appear at hearing, claimant did not waive his right to present his own testimony.

Therefore, we remand this case to the Referee for a hearing on the merits.

IT IS SO ORDERED.

WILLIAM W. PLEMMONS, Claimant	WCB 87-03975
Emmons, et al., Claimant's Attorneys	November 28, 1989
John Motley (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Foster's order that awarded 90 percent (288 degrees) unscheduled permanent disability in lieu of the 25 percent (80 degrees) awarded by prior Determination Orders. Claimant contends that he is permanently totally disabled. We affirm.

ISSUE

Whether claimant has established entitlement to an award of permanent total disability.

FINDINGS OF FACT

We adopt the Referee's Findings, as supplemented by the following additional findings of fact.

Claimant was 58 years of age at the time of the hearing. He had completed high school and had an Associate of Arts degree from a community college. His prior employments included carpentry, cabinet making and work at the Oregon State University physical plant. At the time of his December 1984 injury, claimant had worked for 8 1/2 years for the present employer, operating the employer's vocational workshop for mentally retarded adults.

Claimant returned to work following his 1984 injury. He continued working until he was terminated for allegedly assaulting a mentally retarded woman at work. Claimant was ultimately convicted of the assault and placed on five years probation. He experienced severe and ongoing depression as a result of his legal involvement. One of his primary concerns was that he would have a difficult time becoming reemployed with a criminal record.

Claimant's compensable injury resulted in occipital headaches and neck pain. It also resulted in depression, caused

by claimant's underlying somatic preoccupation with the effects of his injury. However, claimant is physically capable of returning to his job at the time of injury. Thus, his disability is primarily psychiatric.

Claimant is not permanently incapacitated from regularly performing gainful and suitable employment as a result of his compensable injury.

CONCLUSIONS OF LAW

We agree with the Referee's conclusion that claimant is not entitled to permanent total disability. However, we do so for different reasons.

Claimant asserts entitlement to an award of permanent total disability. It is, therefore, his burden to prove that he is permanently incapacitated from regularly performing gainful and suitable employment as a result of his compensable injury. ORS 656.206(1), (3).

As the Referee correctly noted, this is a complex and difficult case. Claimant clearly incurred substantial disability from the effects of his injury, although the effects are primarily psychiatric, rather than physical. All of the physicians in this case agree that claimant remains physically capable of employment in work similar to that he was doing at the time of his injury.

Because claimant's disability is primarily psychiatric, it is necessary to determine the causes of that disability when rating claimant's extent. If the industrial injury materially contributed to claimant's psychiatric problem, then the condition is rated.

Here, there is medical evidence that claimant's industrial injury is a material contributing factor to the psychological condition. The treating psychiatrist and neurologist have found claimant to be permanently disabled. There is contrary medical evidence, however, that claimant is both physically and mentally able to work but has retreated within his disability and made a decision not to return to work.

Given this contrary medical evidence we are unable to accept the opinions of Dr. Kuttner, the treating psychiatrist, and Dr. La France, the treating neurologist, that claimant is so disabled that it would be futile for him to seek work. ORS 656.206(3). Accordingly, claimant has the burden to prove he has made reasonable efforts to find work. This the claimant has not done. We, therefore, agree with the Referee that claimant has failed to prove entitlement to an award of permanent total disability.

ORDER

The Referee's order dated October 9, 1987 is affirmed.

TIMOTHY O. SIMINGTON, Claimant
Coons & Cole, Claimant's Attorneys
Joseph D. Robertson, Defense Attorney

WCB 87-09608
November 28, 1989
Order Denying Request

Claimant requests reconsideration of that portion of our September 20, 1989 Order on Review that declined to award a carrier-paid attorney fee for services rendered on review for successfully prevailing against the self-insured employer's appeal from a Referee's order setting aside its denial of claimant's injury claim. We declined to award an attorney fee because claimant's counsel had not filed a statement of services. Enclosing a statement of services for his counsel's efforts on Board review, claimant seeks an attorney fee pursuant to ORS 656.382(2). The request is denied for lack of jurisdiction.

FINDINGS

On September 20, 1989, the Board issued an Order on Review. Copies of the order were mailed to all parties and their respective counsels. Pursuant to the order, the Referee's order, which set aside the employer's denial of claimant's injury claim, was affirmed. The Board's order further stated that since no statement of services had been received from claimant's counsel, no assessed fee would be awarded. The order has not been appealed, abated, stayed or republished.

The September 20, 1989 order was mailed to claimant's counsel at the address listed on the Referee's order and the employer's request for review. That order was not returned to the Board as undeliverable.

In approximately December 1987, claimant's counsel had moved to a new location. Other than the letterhead of claimant's respondent's brief and cover letter, no express notice of this change of address was received by the Board.

On November 7, 1989, the Board received a statement of services from claimant's counsel.

CONCLUSIONS

Pursuant to our September 20, 1989 order, we found that the compensation awarded by the Referee should not be disallowed or reduced. Since claimant had successfully defended against the employer's appeal of the Referee's order, we reasoned that claimant was entitled to an attorney fee. ORS 656.382(2). However, because no statement of services had been submitted, we held that we were unable to do so. See OAR 438-15-010(5).

Claimant's counsel concedes that he failed to submit a statement of services within 30 days of the issuance of the Board's order. His explanation for this late submission is that the Board's order was mailed to his former office and then subsequently forwarded to his current office. By the time he received the order on October 25, 1989, claimant's counsel states that the 30-day period had elapsed.

Other than a letterhead on claimant's respondent's brief and cover letter, the record contains no express notice to the Board of claimant's counsel's relocation. Under such circumstances, we find claimant's counsel's explanation for a 48-day delay in responding to our order to be unpersuasive.

In any event, an order of the Board is final unless within 30 days after the date of mailing of copies of such orders to the parties, one of the parties appeals to the Court of Appeals. ORS 656.295(8). Attorneys are not parties. ORS 656.005(19); Berliner v. Weyerhaeuser Co., 92 Or App 264, 266, n 1 (1988); Frank F. Pucher, Jr., 41 Van Natta 794 (1989). Thus, even if the Board's order was improperly mailed to claimant's counsel, the 30-day statutory appeal period would continue to run.

Inasmuch as our order was neither appealed, abated, stayed, republished nor withdrawn within 30 days of its issuance, it has become final by operation of law. ORS 656.295(8); International Paper Co. v. Wright, 80 Or App 444, 447 (1986). We have previously concluded that we retain jurisdiction to consider a request for an attorney fee even after the order on the merits has become final by operation of law. See Jane E. Stanley, 40 Van Natta 831 (1988), rev'd on other grounds Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (August 30, 1989). Yet, in order to retain jurisdiction over the attorney fee request, our prior order must not have addressed either the entitlement to, or the amount of, an attorney fee. Gabino R. Orozco, 41 Van Natta 599, 775 (1989).

Here, our September 20, 1989 order addressed claimant's counsel's entitlement to a carrier-paid fee. Since that order has become final by operation of law, we lack jurisdiction to consider the attorney fee request. See Gabino R. Orozco, supra. Accordingly, claimant's request for reconsideration is denied.

IT IS SO ORDERED.

VERNON R. TOSH, Claimant — WCB 87-18383
Lindstedt & Buono, Claimant's Attorneys — November 28, 1989
Daryll E. Klein, Defense Attorney — Order on Review

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Davis' order that: (1) found that claimant's left leg/foot injury claim had been prematurely closed; and (2) set aside those portions of its partial denial that denied the compensability of claimant's neck and low back conditions. We affirm in part and reverse in part.

ISSUES

1. Whether claimant's claim was prematurely closed by the August, 1987 Notice of Closure.

2. Whether claimant's May, 1987, compensable injury materially contributed to the causation of his current neck and low back conditions.

FINDINGS OF FACT

Claimant compensably injured his left foot/leg on May 22, 1987, after slipping at a loading dock. As a result, he sustained a line cortical fracture of the left first metatarsal and abrasions and contusions to the left leg. He sought treatment from Dr. Miller, M.D. Miller temporarily took him off work, due to the metatarsal fracture. On July 31, 1987, Miller found claimant's left foot/leg medically stationary and released him to regular work effective August 3, 1987.

After returning to work on August 3, 1987, claimant experienced a grinding sensation in his knee and pain in his low back. He had never mentioned back pain to Miller. He returned to work on August 4, 1987, but had difficulty with his left foot/leg. He did not return to work thereafter.

On August 14, 1987, claimant returned to Miller with complaints of left foot pain. He did not mention any back problems. Miller detected some left foot tenderness and referred him to a neurologist, Dr. Cohen.

The carrier closed claimant's claim on August 28, 1987, by way of a Notice of Closure. Cohen examined claimant on August 31, 1987, and diagnosed a probable chip fracture of the left first metatarsal. Claimant's fracture was in the process of healing at that time and continued to do so over the next two months.

On October 14, 1987, claimant began to treat with Dr. Holman, a chiropractor. Upon examination, he complained of several symptoms, including: headaches, mid and low back pain, sleeplessness, and irritability. On November 20, 1987, he was examined by Dr. Hunt, an orthopedist, and Dr. Bellville, a psychiatrist, of the Medical Consultants Northwest. Claimant's left foot/leg injury was fully resolved at that time, but he was suffering from a chronic depressive disorder.

A Determination Order issued on November 20, 1987, affirming the insurer's Notice of Closure in all respects.

On December 3, 1987, the insurer issued a denial of compensability for the following symptoms: headaches, neck pain, sleeping problems, mid-back pain, nervousness , tension, irritability, dizziness, fatigue, depression, and buzzing in the ears.

In a December 8, 1987 report to the insurer, Holman reasserted that claimant's left foot/leg condition was not medically stationary and that at least his low back pain arose from the May, 1987 injury. Thereafter, claimant was examined by each Dr. Gritzka, an orthopedist, and Dr. Anderson, a neurologist.

Claimant's left foot was not medically stationary on August 28, 1987. At that time, it was reasonable to expect further material improvement in his left foot by continued medical treatment or the passage of time.

CONCLUSIONS OF LAW

1. Premature Claim Closure

The Board adopts paragraphs one and two of the "opinion" section of the Referee's order.

2. Compensability of Neck and Low Back

The Referee upheld the insurer's December 3, 1987 denial, save for various diagnoses of claimant's neck and low back conditions. We disagree, in part. In our view, the insurer's denial should be upheld in its entirety; i.e., claimant has not established the compensability of his neck and low back conditions.

Absent from the medical reports and chart notes is any

mention of neck or back problems, until claimant began to treat with Holman in October, 1987. Moreover, claimant's supervisor, John Davenport, and the terminal manager, Ron Mills, both testified that claimant never mentioned any such problems. Given the five-month period of not reporting any neck or back problems following the May, 1987 injury, we conclude that the resolution of the compensability question largely turns on the weight of the expert medical opinions. See Uris v. Compensation Department, 247 Or 420 (1967).

a. Neck

The only expert to support the compensability of claimant's neck complaints is Holman. Yet, Holman states: "I cannot tell if the upper back and neck problems are related to this same injury, but he did not have these problems [sic] before his accident." As we understand his opinion, Holman essentially could not tell if the neck condition was related to the May, 1987 injury. Moreover, his basis for speculating otherwise was the chronological sequence of the onset of symptoms to the date of injury. It is well settled, however, that merely a temporal relationship between the onset of symptoms and the date of injury is not persuasive evidence of causation. See Bradshaw v. SAIF, 69 Or App 587 (1984). Finally, Hunt examined claimant and concluded that it would be very difficult to attribute his neck symptoms to the May, 1987 injury.

Under such circumstances, we conclude that claimant has not proven his case with respect to the compensability of his current neck condition.

b. Low Back

The experts are in disagreement over the etiology of claimant's low back complaints. According to Holman, claimant developed an altered gait as a result of the May, 1987 left foot/leg injury, which, in turn, caused low back problems. In contrast, Drs. Anderson and Gritzka opined that claimant's low back complaints arose directly from the mechanics of the May, 1987 slip-and-fall injury. Yet, a reading of the reports from Anderson and Gritzka suggests that neither doctor understood that claimant did not complain of low back difficulties, until five months after the May, 1987 injury. See Miller v. Granite Construction, 28 Or App 473 (1977) (Medical opinion based on inaccurate or incomplete patient history is not persuasive).

Moreover, Anderson and Gritzka said nothing about an altered gait as the etiology for claimant's low back complaints. As to the merits of Holman's altered gait theory, in September, 1987, Cohen found that claimant "walks with a slight left foot limp." On this record, we are not persuaded that claimant's slight left foot limp caused his low back complaints, especially when Anderson and Gritzka offered a completely different causal explanation.

In sum, given the unpersuasive medical record, we conclude that claimant has not proven the compensability of his low back complaints.

Claimant's attorney is entitled to a fee for services on review concerning the permanent closure issue.

ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, such a fee cannot be awarded because no statement of services has been submitted. See OAR 438-15-010(5).

ORDER

The Referee's order, dated March 18, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that set aside the November, 1987 Determination Order and the August, 1987 Notice of Closure as premature is affirmed. That portion of the order that set aside the insurer's December, 1987 denial, insofar as it denied the compensability of claimant's neck and low back conditions, is reversed. Accordingly, the insurer's denial is reinstated and upheld in its entirety. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $360.

DONNA J. WINTERHALTER, Claimant
Douglas L. Schaeffer, Claimant's Attorney
Carrol Smith (SAIF), Defense Attorney

WCB 87-17453 & 87-03477
November 28, 1989
Order on Review

Reviewed by Board Members Nichols and Brittingham.

This is a consolidated review of WCB Case Nos. 87-03477 and 87-17453. In WCB Case No. 87-03477, the SAIF Corporation requests review of that portion of Referee Ebner's order that awarded claimant 95 percent (142.5 degrees) scheduled permanent disability for the loss of use or function of her right leg, whereas a Determination Order awarded no permanent disability. In WCB Case No. 87-17453, SAIF requests review of that portion of Referee Hoguet's order that set aside its denial of claimant's medical services claim.

ISSUES

1. Extent of scheduled permanent partial disability. How much permanent loss of use or function of the right leg did claimant sustain due to the compensable injury?

2. Medical services. Did the compensable injury materially contribute to claimant's current need for medical services?

We reverse on both issues.

FINDINGS OF FACT

Claimant, a 56-year-old medical assistant, struck her right calf against a cart at work on the afternoon of August 21, 1985. Although her leg hurt, she did not seek treatment until the following morning, when she woke with her right calf feeling "warm" and "somewhat hard." She treated conservatively with Dr. Holmes, a vascular surgeon, for pain and swelling in the right leg. When the swelling increased, Holmes admitted claimant to the hospital emergency room for what he diagnosed as right leg thrombophlebitis (inflammation of a vein associated with the aggregation of blood factors). Upon admission, however, diagnostic studies revealed no evidence of deep venous thrombophlebitis. Nevertheless, claimant's symptoms improved with hospitalization for conservative treatment, and she was ultimately

discharged without leg symptoms. SAIF accepted claimant's claim for "[c]ontusion of th [sic] right leg with thromophlibitis [sic]." The claim was ultimately closed by Determination Order on April 16, 1987, with an award of temporary disability only.

Before this compensable injury, claimant had a history of right leg problems. She developed varicose veins in 1956 and has had intermittent right leg pain since then. In early 1973, she saw Dr. Holmes for increased right leg pain. He suspected thrombophlebitis, but a venogram of the leg revealed no evidence of that condition. In May, 1973, Holmes performed right leg surgery for elective vein ligation and stripping. Claimant was discharged with the diagnosis of bilateral varicose veins, worse on the right. She returned to work without difficulty until 1979, when she was struck on the right leg at home, resulting in leg pain. She returned to Holmes, who again suspected deep thrombophlebitis. However, diagnostic studies again revealed no evidence of that condition. After a period of hospitalization for conservative treatment, claimant's leg symptoms subsided until 1985. In June, 1985, claimant experienced right leg pain for one day after undergoing pelvic surgery. A subsequent venogram was negative. Claimant also has a history of obesity and hypertension that pre existed this injury.

In November, 1985, claimant transferred her care to Dr. Chitty, an internist. On September 29, 1987, SAIF denied the compensability of further treatment for the right leg, contending that the leg condition and resulting need for treatment are not related to the compensable injury.

At the time of hearing, claimant continued to have right leg pain and swelling, which impair the use and function of the leg. She last worked in July or August, 1987.

FINDINGS OF ULTIMATE FACT

1. We do not find that claimant sustained any permanent loss of the use or function of the right leg due to the compensable injury.

2. We do not find that the compensable injury materially contributed to claimant's current need for right leg treatment.

CONCLUSIONS OF LAW AND OPINION

Claimant appealed the Determination Order of April 16, 1987 (WCB Case No. 87-03477). Referee Ebner awarded her 95 percent scheduled permanent disability for the loss of use or function of the right leg. Claimant later appealed SAIF's medical services denial of September 29, 1987 (WCB Case No. 87-17453). Referee Hoguet set aside the denial. Claimant separately requested Board review of the Referees' orders. On claimant's motion, those cases were consolidated for review.

WCB Case No. 87-03477: Extent of Permanent Disability

Referee Ebner awarded claimant scheduled permanent disability based on a finding that her disabling leg symptoms were causally related to the compensable injury. We disagree with that finding.

Scheduled permanent disability benefits are intended to compensate an injured worker for the permanent loss of use or function of the injured member "due to the industrial injury." ORS 656.214(2). Here, it is undisputed that claimant suffers right leg symptoms that impair the use or function of that leg. Rather, the dispute is whether those disabling symptoms are due to the compensable injury.

The medical evidence on causation is conflicting. Drs. Holmes and Chitty, the treating physicians, offer the only medical opinions supporting a causal relationship between the current leg symptoms and the compensable injury. Holmes diagnosed deep thrombophlebitis and related it to the injury without explanation. (Ex 13). Chitty appeared less certain of his treating diagnosis; nevertheless, he related the leg symptoms to the injury based on the close temporal relationship between the date of injury and the onset of symptoms. (Ex 42).

The remaining doctors could not identify the etiology of claimant's leg symptoms and were unable to relate them to the injury. Based on his review of claimant's medical records, Dr. Blumberg diagnosed "[p]ain right leg, etiology unknown" and opined that any pain resulting from the compensable injury should have resolved. (Ex 22). Dr. Girod performed an independent medical examination (IME) but could not determine the cause of claimant's problems. He opined that her current leg pain is not related to the compensable injury. (Ex 33). Dr. Holmes later concurred with Girod's report by a check-the-box response. (Ex 39). Dr. Martens reviewed the medical records and related the leg symptoms to chronic phlebitis that preexisted and was not worsened by the compensable injury. He found no permanent impairment due to the injury itself. (Ex 30, 40). Dr. Porter, a vascular surgeon, reviewed the medical records and opined that the current leg pain is not related to either phlebitis or the compensable injury. He could not determine the etiology of the pain, and he found no evidence that claimant has ever suffered venous thrombosis (aggregation of blood factors frequently causing vascular obstruction) in the right leg. (Ex 41, 43).

Although we tend to give greater weight to the opinions of treating physicians, see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so here. Holmes's diagnosis of deep venous thrombophlebitis has never been confirmed by diagnostic studies. Indeed, all of the diagnostic studies on the right leg from 1973 through September, 1985 failed to reveal any evidence of thrombophlebitis. Holmes's persistence in diagnosing thrombophlebitis despite objective medical evidence to the contrary renders his opinion less persuasive, and we discount it accordingly. In any event, Holmes later appeared to change his opinion when he concurred with Dr. Girod, who reported no evidence of deep venous thrombophlebitis and affirmatively stated that claimant's current leg pain is unrelated to the compensable injury.

Chitty did not appear to have a clear diagnosis of claimant's leg problems. However, he relied on the close temporal relationship between the injury and the onset of symptoms in finding a causal relationship. We generally hesitate to infer causation from the mere temporal sequence of events. See Bradshaw v. SAIF, 69 Or App 587, 589-90 (1984); Edwards v. SAIF, 30 Or App 21, 24, rev den 279 Or 301 (1977). We decline to infer causation here, because there are alternative causes for

claimant's leg problems aside from this injury. Claimant has a long history of right leg symptoms dating back to 1956, which have been attributed to either varicose veins or thrombophlebitis. Moreover, the etiology of claimant's current symptoms is unknown despite numerous diagnostic studies. Finally, claimant has not had continuing leg pain since the injury. Upon her discharge from the hospital on September 12, 1985, Holmes reported that claimant was "ambulating and asymptomatic". (Ex 16). A week later, claimant saw Dr. Hazel with leg pain. (Ex 18). Although claimant testified that her leg pain continued uninterrupted after the injury, we find that testimony unreliable in the face of more persuasive documentary evidence. Under these circumstances, we decline to infer causation from temporal sequence and discount Chitty's opinion accordingly.

Instead, we rely on the thorough and well-reasoned opinions of Drs. Blumberg, Girod and Porter. See Somers v. SAIF, 77 Or App 259, 263 (1986). Therefore, we do not find that claimant's current leg complaints are related to the compensable injury. Accordingly, we do not find that claimant has sustained any permanent loss of use or function of the right leg due to the compensable injury.

WCB Case No. 87-17453: Medical Services

The parties stipulated to incorporate by reference the record in WCB Case No. 87-03477 as the record in this case. Based on that record, Referee Hoguet found that "the issue raised in this case was[,] in fact, litigated in WCB Case No. 87-03477." He then found that the compensable injury had materially contributed to claimant's leg condition and resulting need for treatment. We disagree.

The Referee apparently applied the res judicata rule of "issue preclusion," which provides that, if an issue of fact or law is actually litigated and determined by a valid final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. See North Clackamas School Dist. v. White, 305 Or 48, 53 (1988); Restatement (Second) of Judgments § 27 (1982). Although the causal relationship between claimant's compensable injury and her current leg condition was actually litigated before the Referee in WCB Case No. 87-03477, the Referee's order in that case did not become "final" because it was appealed within 30 days after its mailing date. See ORS 656.289(3). Hence, res judicata does not apply to preclude the parties from relitigating the causal relationship between the compensable injury and the current leg condition. We now proceed to the merits.

To establish the compensability of treatment for the right leg condition, claimant must prove that the compensable injury materially contributed to that condition and the resulting need for treatment. ORS 656.245(1); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Jordan v. SAIF, 86 Or App 29, 32 (1987). Consistent with our reasoning in WCB Case No. 87-03477, we are most persuaded by the opinions of Drs. Blumberg, Girod and Porter. We find, therefore, that claimant has not sustained her burden of proving that her current right leg condition and need for treatment are materially related to her compensable injury.

ORDER

In WCB Case No. 87-03477, the Referee's order dated November 6, 1987, as amended December 21, 1987, is reversed. The Referee's award of 95 percent (142.5 degrees) scheduled permanent disability for the loss of use or function of the right leg is reversed. The Determination Order of April 16, 1987, is reinstated and affirmed. The Referee's award of an attorney fee payable out of increased compensation is disallowed.

In WCB Case No. 87-17453, the Referee's order dated March 8, 1988, is reversed. The SAIF Corporation's medical services denial of September 29, 1987 is reinstated and upheld. The Referee's award of an assessed fee to claimant's attorney is disallowed.

JAMES P. BOWERS, Claimant
Brian Whitehead, Claimant's Attorney
Randolph Harris (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys
Davis, et al., Defense Attorneys

WCB 87-10225, 87-05574 & 87-06625
November 29, 1989
Order on Reconsideration

Claimant has requested reconsideration of our November 3, 1989 Order on Review. Specifically, claimant contends that we did not address the merits of his 1979 aggravation claim. He further contends that his counsel is entitled to a greater attorney fee than awarded by our order. The SAIF Corporation has also requested reconsideration, contending that claimant's counsel is not entitled to an attorney fee in conjunction with its unreasonable failure to process claimant's 1979 aggravation claim. After considering claimant's motion and memorandum in support and SAIF's motion and memorandum in support, we issue the following order.

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the compensable injury. Perry v. SAIF, 307 Or 654 (1989); ORS 656.273(1). To prove a worsening, claimant must show that he is more disabled, i.e. less able to work, since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986).

Claimant's last arrangement of compensation was the October 1978 Referee's order which awarded claimant 30 percent scheduled disability for loss of use of function of the left hand and did not award any additional unscheduled disability beyond the 15 percent previously awarded. At the time of closure, medical evidence indicated that claimant had atrophy on the infraspinatus, weak external rotators and winging of the scapula. (Ex. 20).

On April 24, 1979, claimant was examined by Dr. Berselli who reported that claimant continued to have atrophy and that he would make a good candidate for the fusion surgery. On June 19, 1979, Dr. Berselli requested authorization for the surgical procedure and stated that claimant's condition had worsened. On August 28, 1979, Dr. Berselli noted that claimant's condition was "status quo" and that the atrophy persisted. In February 1980, Dr. Berselli stated that he had no treatment, other than surgery to offer claimant.

Although Dr. Berselli's June 29, 1987 report indicating that claimant's condition had worsened was sufficient to trigger SAIF's duty to accept or deny the claim, it does not establish a aggravation on the merits. Assuming that Dr. Berselli's statement that claimant's condition had worsened establishes that his physical condition was exacerbated at that time, it does not establish that he was more disabled. Further, there is no persuasive evidence that claimant missed any time from work during this time period, or that time loss was authorized.

Under these circumstances, we conclude that claimant has failed to establish that he sustained a compensable aggravation in 1979. Therefore, a reopening of his claim as of June 1979 is not appropriate.

With regard to claimant's request for increased attorney fees, we conclude that our order adequately compensated claimant's counsel and decline to increase his attorney fee. In this regard, we note that claimant did not prevail on every issue raised in his appeal. Finally, our order adequately addresses SAIF's motion and we decline to discuss the issue further.

Accordingly, our November 3, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

PATRICIA L. DUERR, Claimant
Coons & Cole, Claimant's Attorneys
Luvaas, et al., Defense Attorneys

WCB 89-09814
November 29, 1989
Order of Dismissal

Reviewed by Board Members Gerner and Cushing.

The insurer has moved for an order dismissing claimant's request for review of a Referee's order on the grounds that claimant did not request review. The motion is granted.

FINDINGS

The Referee's order issued September 22, 1989. By letter dated October 11, 1989, claimant requested reconsideration of the Referee's order. Claimant's request was addressed to the attention of the Referee at the Hearings Division for the Board. The request was not mailed by certified mail.

There is no record that claimant's reconsideration request was received by the Referee or Board until November 13, 1989. On that date, claimant submitted a copy of his October 11, 1989 reconsideration request. In a November 9, 1989 cover letter to the Board, claimant asked that the October 11, 1989 request be considered as a request for Board review of the Referee's order. On November 17, 1989, the Board mailed a computer-generated letter to the parties acknowledging a request for review.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). 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).

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to properly identify a document as a party's request for Board review of a Referee's order. Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

Here, we have no record of receiving claimant's October 11, 1989 request until November 13, 1989. Thus, the request is untimely, since it was received more than 30 days after the Referee's order. Even assuming that the October 11, 1989 request had been timely submitted, claimant expressly moved the Referee for reconsideration of the order. No request for Board review of the order was mentioned.

Under such circumstances, we conclude that the intention expressed in claimant's October 11, 1989 request is both clear and unmistakable. i.e., she was asking the Referee to reconsider the Opinion and Order. Consequently, we hold that claimant's October 11, 1989 request does not constitute a request for Board review of the Referee's September 22, 1989 order.

Claimant's November 9, 1989 cover letter, which accompanied the copy of the October 11, 1989 request, does express an intention to request review of the Referee's September 22, 1989 order. Thus, that letter, which was received by the Board on November 13, 1989, does constitute a request for Board review. However, November 13, 1989 is more than 30 days after the Referee's September 22, 1989 order. Consequently, the request for review is untimely. ORS 656.289(3); 656.295(2).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

CATARINO GARCIA, Claimant	WCB 86-01910
Emmons, Kropp, et al., Claimant's Attorneys	November 29, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of that portion of Referee Peterson's order which granted claimant permanent total disability, whereas a Determination Order had awarded 25 percent (80 degrees) unscheduled permanent disability for a low back injury. Claimant cross-requests review of that portion of the order which upheld the insurer's denial of his medical services claim for a low back condition. On review, the issues are extent of disability, including permanent total disability, and reasonableness and necessity of medical services. We reverse.

FINDINGS OF FACT

Claimant sustained a work-related low back injury in January 1981. He was treated conservatively and the symptoms resolved within two months. In January 1983, claimant again sought treatment for low back symptoms. He discontinued treatment after a few weeks and was declared medically stationary with no permanent impairment.

In June 1984, claimant sustained another compensable low back injury. He sought treatment from Dr. Neil Cohen, chiropractor, who diagnosed a lumbosacral strain. Claimant's symptoms did not resolve and he was referred to Dr. Lawrence Cohen, orthopedist. A myelogram revealed a ruptured disc at L4-5. Thereafter, in November 1984, Dr. Lawrence Cohen performed a L4-5 and L5-S1 laminectomy with partial removal of the L4-5 disc.

In early 1985, Dr. Olson, M.D., became claimant's treating physician. He referred claimant to the Northwest Pain Center. Claimant was discharged on the first day. In May 1985, vocational assistance began. A January 1986 Determination Order closed claimant's claim with an award of 25 percent unscheduled permanent disability. In March 1986, vocational assistance was terminated due to non-cooperation. Claimant's vocational counselor reported that he had had numerous meetings and telephone contacts with claimant, but that claimant had refused to cooperate in formulating a return to work program.

In January 1987, claimant began treating with Dr. Pearson, chiropractor. On January 28, 1987, the insurer denied Dr. Pearson's treatment on the basis that it was not reasonable or necessary.

Claimant, 42 years of age at hearing, has a second grade education in Mexico and cannot read or write. He is unable to do any mathematics other than simple addition. His ability to speak and understand English is limited. His prior work experience is as a field worker and a nursery laborer. He worked for the employer's nursery for 10 years prior to the compensable injury.

Claimant can lift 20 pounds from table height and 15 pounds from ground level. He is able to stand for up to an hour. He cannot do any repetitive bending, twisting, lifting, or prolonged sitting. As a result of his compensable injury, he has sustained permanent impairment in the mild to moderate range.

FINDINGS OF ULTIMATE FACT

Claimant is not permanently incapacitated from regularly performing work at a gainful and suitable occupation.

Claimant has not made reasonable efforts to seek or obtain gainful, suitable employment.

Claimant's current need for medical treatment is reasonable and necessary as a result of his compensable low back injury.

CONCLUSIONS OF LAW

Permanent Total Disability

The Referee concluded that claimant was permanently and totally disabled. We disagree.

To establish permanent total disability, claimant must prove that he is unable to regularly perform work at a gainful and suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977); ORS 656.206(2). Claimant may prove permanent total disability under the "odd lot" doctrine by a combination of his medical disability and nonmedical factors such his age, education, work experience, training, and mental capacity. Shaw v. SAIF, 78 OR App 588 (1986). In addition, claimant has the burden to establish that he is willing to seek regular, gainful employment and has made reasonable efforts to obtain such employment. ORS 656.206(3).

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of his physical condition. Dr. LaFrance opined that claimant has mild to moderate impairment, due to pain, but that he was not precluded from light to sedentary work. Dr. Stolzberg agreed that claimant could do such work, and noted that claimant's behavior during examination was anatomically inconsistent and exaggerated. Dr. Lawrence Cohen also noted inconsistencies between claimant's pain behavior and his objective findings and felt that his low back condition should have improved more than claimant professed, following the successful surgery.

Dr. Olson has opined that claimant is unemployable. However, he too notes that his assessment is based on subjective complaints and not on objective findings. He further opined that claimant could probably perform some type of work if rehabilitation was successful.

We conclude that claimant is physically capable of light to sedentary work. In reaching this conclusion, we note that Dr. Olson's opinion that claimant is unemployable is a vocational conclusion and takes into consideration nonmedical factors. Accordingly, to the extent his opinion is based on such nonmedical factors, we do not find it persuasive.

We next turn to the nonmedical factors. Claimant was 42 years old at the time of hearing. He has a second grade education in Mexico and his ability to speak and understand English is limited. His prior work experience consists of being a field worker and a nursery laborer.

Raymond Rees a vocational expert opined that claimant was not employable at anything other than an entry level job at minimum wage. He testified that it was his understanding that suitable employment was employment that was compatible with claimant's preinjury wage. Although this is a relevant inquiry in regards to the suitability of a vocational plan, compatibility with preinjury wages is not determinative in a permanent total disability setting. Accordingly, we are not persuaded that claimant is permanently restricted from performing suitable, gainful work due to nonmedical factors.

Finally, we conclude that claimant has not established that he is willing to seek suitable work and has made reasonable efforts in this regard. Claimant's vocational assistance was terminated due to noncooperation. His noncooperation was largely based on claimant's perception that he was unemployable and could not return to work until he was free of pain. Such a perception was in direct conflict with his physical limitations as prescribed by his medical providers. Therefore, vocational efforts would not have been futile, and claimant's noncooperation was unreasonable under the circumstance. ORS 656.206(3)

Extent of Permanent Disability

Although we have concluded that claimant is not permanently and totally disabled, we do find that he has lost earning capacity in excess of the 25 percent unscheduled permanent disability awarded by Determination Order. Considering our findings regarding claimant's injury-related impairment and the nonmedical factors pertinent to the evaluation of loss of earning capacity, we conclude that an award of 50 percent unscheduled permanent disability more accurately compensates claimant for his loss of earning capacity.

Reasonableness and Necessity of Medical Services

The Referee concluded that claimant's current treatment for his low back condition was not reasonable and necessary as a result of his compensable 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." ORS 656.245(1). Medical services are compensable provided they are reasonably and necessarily incurred in the treatment of the compensable injury. West v. SAIF, 74 Or App 317, 320 (1985).

The only medical evidence is an 827 report from claimant's treating chiropractor, Dr. Pearson. Dr. Pearson had previously treated claimant in 1983. The report refers to the claim number of claimant's original injury and indicates low back pain with a diagnosis of left L5-S1 disc protrusion.

Claimant credibly testified that Dr. Pearson's treatment has helped him and has reduced his low back pain. Moreover, he has continued to experience low back pain since the June 1984 injury and resulting disc surgery. There is no persuasive evidence in the record that suggests that claimant's current treatment is not causally related to his compensable injury. Given claimant's continued pain and medical treatment since the 1984 injury, we conclude that his current condition remains materially related to that injury. Further, there is no evidence in the record that suggests the treatment is not reasonable and necessary.

We conclude that Dr. Pearson's report, combined with claimant's credible testimony, establish that claimant's current treatment for his low back condition is reasonable and necessary treatment for the compensable injury. Accordingly, the treatment is compensable.

ORDER

The Referee's order dated May 12, 1987, as clarified June 11, 1987, is reversed in part and affirmed in part. That portion which awarded claimant permanent total disability is reversed. In lieu of the Referee's award of permanent total disability, and in addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by Determination Order, claimant is granted 25 percent (80 degrees) unscheduled permanent disability for a total of 50 percent (160 degrees) unscheduled permanent disability. Claimant's attorney's fees shall be adjusted accordingly. That portion of the Referee's order which upheld the insurer's denial of medical services is reversed. The denial is set aside and the claim is remanded for processing according to law. For services at hearing and on Board review, concerning the medical services issue, claimant's counsel is awarded an assessed fee of $1,525. A client-paid fee, not to exceed $160, is approved. The remainder of the Referee's order is affirmed. Our November 23, 1988 Interim Order is incorporated herein by this reference.

GEORGE V. LYNESS, Claimant	WCB TP-89018
Francesconi & Associates, Claimant's Attorneys	November 29, 1989
James E. Griffin, Assistant Attorney General	Third Party Order on Reconsideration

Claimant has requested reconsideration of our October 31, 1989 Third Party Distribution Order, which concluded that the SAIF Corporation, as a paying agency, was entitled to a share of the proceeds from a third party settlement and that a distribution in accordance with ORS 656.593(1) was "just and proper." Specifically, for the first time, claimant requests an evidentiary hearing "so that [he] can cross-examine SAIF Corporation's witnesses." The request is denied.

Petitions for the resolution of disputes concerning third party matters shall clearly identify the party seeking relief, the relevant facts, the nature of the dispute, and the relief sought. OAR 438-11-045(2). All relevant evidence shall be attached to the petition, with testimonial evidence provided by deposition, affidavit, or written interrogatories. id.

Here, upon the Board's receipt of SAIF's petition for third party relief, the parties were expressly advised by staff counsel for the Board of the aforementioned rule. In response to this advisement, both parties submitted affidavits concerning their dispute. Each of the parties responded to the statements contained in the other's affidavits. Neither party objected to this procedure nor sought an evidentiary hearing. Rather, they each relied upon their affidavits, the remaining documentary record, and their legal arguments in support of their respective positions.

Records concerning third party disputes must be sufficiently developed to sustain judicial review under ORS 656.298. See Blackman v. SAIF, 60 Or App 446, 448 (1982). Here, we consider the present record to be developed sufficiently to meet such a standard. Thus, we are not inclined to reopen the record for purposes of referring this matter for additional evidence taking.

Furthermore, prior to our order, claimant was content to rebut the statements offered in the affidavits from SAIF's witnesses through the submission of his counsel's affidavit and rebuttal. It was only after the issuance of our order that claimant sought an evidentiary hearing for the purposes of cross-examining SAIF's witnesses. We have previously considered such post-order evidentiary requests, to be highly suspect, particularly when a party has had an ample opportunity to present the case. See Donald P. Bond, 40 Van Natta 480 (1988).

Here, as in Bond, we consider claimant's referral request to be ill-timed. Thus, we continue to adhere to the reasoning that, to grant such a request and reopen the record at this late date, would potentially expose the Board to an endless string of reconsideration requests and offers to submit additional evidence, all designed to respond to conclusions reached by a previous third party order.

Accordingly, our October 31, 1989 order is withdrawn. Claimant's request for an evidentiary hearing is denied. On reconsideration, as supplemented herein, we adhere to and republish our October 31, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ROBERT E. PARKS, Claimant
Malagon, et al., Claimant's Attorneys

Own Motion 88-0191M
November 29, 1989
Own Motion Order on Reconsideration

Claimant and the self-insured employer request reconsideration of our November 2, 1989, Own Motion Order Reviewing Self-Closure that awarded claimant additional temporary disability benefits through the date that he became medically stationary, less time worked. Claimant contends that the employer's termination of temporary disability benefits prior to the medically stationary date was unreasonable and seeks a penalty and related attorney fee. Additionally, claimant's attorney submits an attorney retainer agreement, seeking approval of an attorney fee payable out of compensation awarded by our November 2, 1989, order. The employer contends that its initial termination of temporary disability benefits was proper.

The employer submits copies of work releases from claimant's physician and the employer's medical department. Copies of those releases were contained in the record during our initial review of this claim closure, but we did not find them probative of claimant's return to regular work at his regular wage. If the claimant returned to work on the date of release, the employer should have submitted evidence of claimant's actual return to work, such as payroll records, along with its Notice of Closure. Absent such evidence, we conclude that our original order adequately addresses the employer's contention. Hence, its reconsideration request is denied.

Claimant argues that, in the absence of any evidence that he actually returned to regular work on or after June 6, 1988, the employer's initial termination of temporary disability benefits as of June 5, 1988, rather than the medically stationary date of June 28, 1988, was unreasonable. We agree. Accordingly, the employer is assessed a penalty in the amount of 25 percent of any amounts of

temporary disability benefits that were due from June 6, 1988, through June 28, 1988. Claimant's attorney is also awarded a penalty-related assessed fee of $50.

Finally, we have reviewed the attorney retainer agreement submitted by claimant's attorney. Claimant's attorney is awarded 25% of the additional compensation granted by our November 2, 1989, order, not to exceed $100, as a reasonable attorney fee.

Our November 2, 1989, order is abated and withdrawn. On reconsideration, as amended and supplemented herein, we adhere to and republish our November 2, 1989, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

DONALD V. PITTMAN, Claimant
Rasmussen & Henry, Claimant's Attorneys
Schuyler Wallace, Defense Attorney

WCB 86-14185
November 29, 1989
Order on Reconsideration

Claimant has requested reconsideration of our November 14, 1989, Order on Review, which: (1) upheld the self-insured employer's denial of his low back injury claim; and (2) declined to assess either a penalty or an assessed attorney fee. In his request, claimant correctly points out that our November 14, 1989, order lacked a notice of the parties' appeal rights. In addition, he contends that this case should be rereviewed by a panel of Board members, which excludes Board Member Myers and Board Member Nichols.

We agree that we inadvertently omitted a notice of the parties' appeal rights in our November 14, 1989, order. We do not agree with claimant's recusal contentions.

For the purpose of completeness, we will look to the merits of the request. The basis for claimant's recusal motion of Board Member Myers, is that Board Member Myers previously presided as a Referee in a hearing involving claimant. We do not dispute that claimant previously appeared in a hearing, wherein Board Member Myers was the Referee. Ex. 11. However, Board Member Myers had no involvement in this case on Board review. This case was decided on the record solely by Board Member Gerner and Board Member Cushing. Inasmuch as Board Member Myers did not involve himself in the review of this case, there is nothing for him to recuse himself from.

Turning to the motion to recuse Board Member Nichols, she was the Referee in this case at the hearing below. However, as we found above with Board Member Myers, Board Member Nichols had no involvement in the review of this case. This case was decided on the record solely by Board Member Gerner and Board Member Cushing. As such, Board Member Nichols has nothing to recuse herself from.

Accordingly, our November 14, 1989, order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 14, 1989, order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

RICHARD BRAUN and IRENE BRAUN, dba,
IRENE'S, Employer
Robert R. Harrison, Attorney
David Smith (SAIF), Attorney

WCB 87-18687
November 30, 1989
Order of Dismissal

Richard and Irene Braun (dba "Irene's"), the alleged noncomplying employers, request review of Referee Zucker's order which affirmed the Workers' Compensation Department's Proposed and Final Order finding them to be a noncomplying employer. The issue on review is jurisdiction. We dismiss the request for review.

FINDINGS OF FACT

On November 13, 1987, the Director issued a Notice of Proposed and Final Order declaring that Richard Braun and Irene Braun were doing business as a partnership, which was a noncomplying employer. At the employer's request, a hearing was held before the Referee. Evidence was admitted on the issue of noncompliance. Thereafter, the Referee issued an order affirming the Director's proposed order.

CONCLUSIONS OF LAW AND OPINION

If any party requests a hearing on a Director's Order regarding noncompliance or any other matter unrelated to a claim, the Board appoints a Referee to hold a hearing. ORS 656.283(4); Heinz J. U. Sauerbrey, 37 Van Natta 1512 (1985). That is our only involvement in cases such as this. When the Referee issues an order, it is then a final order of the Director and must be appealed directly to the Court of Appeals. ORS 183.480(1), (2); See Denise K. Rodriguez, 40 Van Natta 1788 (1988).

Since we lack jurisdiction to review the Referee's order, we must dismiss the request for review.

ORDER

The request for Board review is dismissed.

SHEILA A. CRESS, Claimant
Malagon, Moore & Johnson, Claimant's Attorneys
Kate Donnelly (SAIF), Defense Attorney
Acker, Underwood et al., Defense Attorneys

WCB 86-15248 & 87-14036
November 30, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

The self-insured employer ("employer") requests review of that portion of Referee Myer's Interim Order, which found that claimant had proven "good cause" for filing her request for hearing beyond the 60-day period of ORS 656.319(1)(a), as well as those portions of Referee Mirassou's order that: (1) set aside its aggravation denial for claimant's left wrist condition; and (2) upheld the SAIF Corporation's "new injury" denial of the same condition. On review, the issues are timeliness, compensability, and responsibility.

The Board affirms and adopts the order of Referee Myers. We have recently held that a delay in receipt of actual notice of a denial may constitute good cause for a late request for hearing. Jeffrey A. Domber, 41 Van Natta 1236 (1989). We also affirm and adopt the order of Referee Mirassou with the following additional ultimate finding.

Claimant's work activities at SAIF's insured did not independently contribute to a worsening of her underlying left wrist condition.

ORDER

Referee Myers' order dated March 12, 1987, as well as Referee Mirassou's order dated March 21, 1988, as reconsidered on April 19, 1988 are affirmed. Claimant's attorney is awarded an assessed fee of $700, to be paid by the employer. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $918.

WARREN C. ROCK, Claimant	WCB 87-18956
Robert Grant, Claimant's Attorney	November 30, 1989
Arthur Stevens (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Brown's order that affirmed the Director's order, which found that claimant was not entitled to further vocational services. On review, the issue is whether the Director's order may be modified pursuant to ORS 656.283(2)(a) to (d).

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

The administrative rules in effect on the date of claimant's injury control. Frame v. Crown Zellerbach, 63 Or App 827 (1983). One rule in effect at that time was OAR 436-61-010 (a), which provided:

"Injured workers have no entitlement to services under these rules if:

* * *

(b) they have been reemployed, but leave for reasons not directly caused by their compensable injury; * * *."

Claimant was reemployed following his authorized training program. He left that reemployment to pursue self-employment. He did not leave as a direct result of his compensable injury.

The Director's order has not been shown to have violated a statute or rule. It was within the Director's authority and there has been no showing of unlawful procedure or abuse of discretion.

ORDER

The Referee's order, dated March 15, 1988, is affirmed.

DEL VAN CAMP, Claimant
CNA, Insurance Carrier

Own Motion 89-0355M
November 30, 1989
Own Motion Determination

The insurer voluntarily reopened claimant's claim for a worsened condition related to his industrial injury of November 4, 1974. The claim has now been submitted for closure. We decline to close claimant's claim.

Claimant's doctors recommended repeat surgery to refuse the low back; however, claimant declined to submit to surgery. Subsequently, on May 16, 1989, Dr. Waller, the treating microneurosurgeon, noted continuing symptoms in the left leg and indicated that further non-surgical treatment would be conservative. He asked claimant to schedule a return appointment in three months; however, there is no indication that such an appointment was scheduled. Additionally, on May 16, 1989, Dr. Wisdom, the treating orthopedist, noted right hand symptoms relating to claimant's use of a cane for the low back condition. Wisdom suggested that claimant alter his grasp of the cane and indicated that claimant "may need to be redeclared stationary in the near future and have his claim closed." There is no subsequent medical report declaring claimant medically stationary.

Notwithstanding medical evidence that further non-surgical treatment would be conservative only and would not be curative, the record does not support a finding that claimant is yet medically stationary. There is no medical evidence that either affirmatively declares claimant medically stationary or addresses the question of whether further material improvement in claimant's condition would reasonably be expected from the passage of time, as well as medical treatment. See ORS 656.005(17). Because we do not find that claimant is yet medically stationary, closure of his claim would be premature at this time. Accordingly, the insurer's own motion request for claim closure is denied. The claim shall be resubmitted for closure when medical reports persuasively indicate that claimant is medically stationary.

IT IS SO ORDERED.

JANET E. VOORHIES, Claimant
S. David Eves, Claimant's Attorney
Kate Waldo (SAIF), Defense Attorney

WCB 87-11287
November 30, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Holtan's order which upheld the SAIF Corporation's partial denial of claimant's current back and right shoulder condition. The issue on review is compensability. We affirm.

FINDINGS OF FACT

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

Claimant's back and right shoulder condition has remained unchanged since the December 16, 1986 Stipulated Order.

CONCLUSIONS OF LAW AND OPINION

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

We do not agree that the present claim is barred by either res judicata or collateral estoppel. Nevertheless, we agree with the Referee's ultimate conclusion.

Pursuant to the December 16, 1986 Stipulated Order, SAIF's denial of claimant's then-current condition was upheld. That order was not appealed and, therefore, has become final by operation of law. ORS 656.289(3). Consequently, in order to establish that her present back problem is compensable, claimant must prove by a preponderance of the evidence that her current condition is different, or changed, from her condition in December 1986. See Proctor v. SAIF, 68 Or App 333 (1984). That is, claimant must reestablish the chain of medical causation between her injury and her back condition since the continuity of that connection was interrupted as a matter of law by the 1986 settlement.

Claimant has failed to sustain this burden. Claimant contends that her current symptoms are the result of a chronic strain, not ideopathic scoliosis as was the cause in December 1986. However, the facts do not persuade us that claimant's current condition is different from the condition which originally was disputed and settled in December 1986. To the contrary, claimant testified that her symptoms have remained essentially unchanged.

We conclude, therefore, that regardless of the diagnosis, claimant's current condition is the same as that settled and determined noncompensable in December 1986. Consequently, pursuant to the December 1986 Stipulated Order, her present claim is not compensable.

ORDER

The Referee's order dated April 19, 1988 is affirmed.

BRADFORD N. APPLEWHITE, Claimant	WCB 86-15553
David C. Force, Claimant's Attorney	December 1, 1989
Brian L. Pocock, Defense Attorney	Order on Reconsideration

Claimant has requested reconsideration of that portion of our October 25, 1989, Order on Review, which declined to award an assessed attorney fee. On November 22, 1989, we issued an Order of Abatement requesting a response from the employer. We have received the employer's response. Accordingly, we proceed to address claimant's request for an assessed fee.

Specifically, claimant asserts two arguments for an assessed fee: (1) the employer's allegedly unreasonable resistance to the payment of compensation, ORS 656.382(1); and (2) partially prevailing against the employer's alleged cross-request for hearing on the issue of entitlement to an offset for overpaid temporary disability compensation, ORS 656.382(1). Inasmuch as claimant asserted both arguments in his Appellant's Brief, but we only addressed the first argument in our order of October 25, 1989, we turn to that second argument.

The employer did not formally or informally cross-request a hearing. A Determination Order of October, 1987, expressly authorized the employer to offset any overpaid temporary

disability compensation. Thereafter, claimant requested a hearing including the issue of an "[u]nlawful overpayment recovery" by the employer. The employer, however, never formally or informally cross-requested a hearing. At the hearing, the employer defended against claimant's case that there was no lawful overpayment of temporary disability compensation. According to the employer, it had overpaid $1,279.84 in temporary disability compensation.

The Referee found that the employer had, in fact, overpaid temporary disability compensation. In so doing, however, he reduced the amount of the alleged overpayment from $1,279.84 to $1,163.08. In essence, the Referee ordered the employer to pay claimant $116.76 in temporary disability compensation. Therefore, claimant did not prevail at the hearing against an employer "initiated" cross-request, as required by ORS 656.382(2). He did prevail, however, in obtaining increased temporary disability compensation. Accordingly, his attorney is entitled to an approved fee under ORS 656.386(2), payable out of that increased compensation, and not an assessed fee payable from the employer.

On this record, the employer did not initiate a cross-request for hearing seeking Referee authorization of an offset of allegedly overpaid temporary disability compensation. Rather, claimant raised the issue of an "[u]nlawful overpayment recovery." The employer defended against claimant's case for no overpayment. Under such circumstances, no fee under ORS 656.382(2) is warranted.

Claimant's attorney is awarded an approved fee equal to 25 percent of the $116.76 increased compensation awarded by this order.

Accordingly, our October 25, 1989, order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 25, 1989, order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

DENNETTE D. DALE, Claimant
Black, et al., Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 88-01394
December 1, 1989
Order on Review (Remanding)

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Thye's order that dismissed claimant's request for hearing due to claimant's failure to appear at the time and place set for hearing. Claimant seeks to have the dismissal set aside and an order remanding the case to the Hearings Division for a hearing on the merits. We reverse and remand.

ISSUE

Whether claimant's request for hearing should have been dismissed due to claimant's failure to appear.

FINDINGS OF FACT

On April 13, 1988, the insurer's attorney and claimant's attorney appeared at hearing. Claimant did not appear. The insurer moved to dismiss claimant's request for hearing. The

Referee recited that claimant's attorney had made an off the record representation that he did not know whether claimant would appear because claimant was living in Oklahoma and he did not know if she would be able to make arrangements to appear at hearing. The Referee then cited former OAR 438-06-071 as authority and indicated on the record that he would dismiss claimant's request for hearing. Claimant's attorney moved for a postponement. The Referee denied the motion, but stated that claimant could renew her motion while the Referee retained jurisdiction.

On April 20, 1988, the Referee issued an order of dismissal, again relying on former OAR 438-06-071 for authority. The Referee concluded that claimant had not established extraordinary circumstances beyond her control which would justify a postponement under former OAR 438-06-071. Claimant did not renew her motion to postpone. Rather, she simply requested review of the Order of Dismissal.

CONCLUSIONS OF LAW

The Referee relied on former OAR 438-06-071 which states:

> "Failure of a party or the party's representative to appear at the time and place scheduled for a hearing is a waiver of appearance. If the party that fails to appear is the party that requested the hearing, the referee shall issue an order dismissing the request for hearing for failure to appear unless a postponement is granted under 438-06-081."

Former OAR 438-06-081 allows postponements only upon a showing of extraordinary circumstances. It includes examples of circumstances which are not extraordinary circumstances.

We conclude that the Referee was incorrect in dismissing the hearing request based on claimant's failure to appear at the hearing. In Williams v. SAIF, 99 Or App 367 (November 8, 1989), the court recently held that, under the current version of OAR 438-06-071, Referees are not authorized to dismiss a claimant's hearing request simply because the claimant did not appear at the hearing. The court reasoned that a claimant was entitled to offer the remainder of his/her evidence, even if he/she chose not to testify personally. The court further stated that the choice not to testify did not prevent an insurer from presenting its evidence in defense of the claim.

The relevant language of the version of OAR 438-06-071 cited above and the current version cited by the court in Williams is substantially the same. Both provide that if a party or the party's attorney fail to appear at the hearing, then failure to appear is a waiver of appearance and is grounds for dismissal if the party waiving is the party which requested the hearing.

Here, although claimant did not appear at the hearing, her attorney was present and prepared to proceed with the case on the record. In accordance with the Williams reasoning, claimant's failure to appear is not grounds for dismissal under OAR 438-06-071. Accordingly, we conclude that the hearing request should not have been dismissed.

We turn to the question of whether claimant waived her right to testify. At hearing, claimant's attorney moved for a postponement to attempt to establish whether claimant had established extraordinary circumstances which would justify a postponement. The Referee denied the motion, but stated that claimant could renew her motion while the Referee retained jurisdiction. Claimant did not renew her motion. Rather, she requested review.

We agree with the Referee that, based on the representations of claimant's counsel, claimant failed to establish extraordinary circumstances which would have justified a postponement. Considering the fact that the Referee explicitly gave claimant leave to renew her motion while he retained jurisdiction, we conclude that the Referee adequately developed the record on the postponement motion. Accordingly, we conclude that by her failure to appear, claimant has waived her right to testify at hearing.

Consequently, we remand to the Hearings Division for a hearing. At hearing, the Referee shall not allow claimant to testify but, otherwise, may hear testimonial evidence. He shall make whatever evidentiary rulings on the written record that are appropriate and shall decide the case without benefit of claimant's testimony.

ORDER

The Referee's order, dated April 20, 1988, is reversed. This case is remanded to the Referee for further proceedings consistent with this order.

EDWARD T. DORRIS, Claimant	WCB 86-17704
Malagon & Moore, Claimant's Attorneys	December 1, 1989
E. Jay Perry, Defense Attorney	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Garaventa's order that : (1) upheld the insurer's partial denial of claimant's low back surgery; and (2) excluded a medical report submitted by claimant. Claimant also seeks remand for the admission of the rejected medical report. The issues on review are the Referee's evidentiary ruling, remand, and compensability.

With regard to the remand issue, we find that the record has not been improperly, incompletely, or otherwise insufficiently developed at the hearing. ORS 656.295(5). Furthermore, to merit remand for consideration of additional evidence, it must be clearly shown that the evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). Here, we are not persuaded that the proffered medical report was unobtainable with due diligence at hearing. Accordingly, the motion to remand is denied.

The Board affirms and adopts the order of the Referee with the following supplementation concerning the compensability issue.

Claimant contends that the insurer is prohibited from issuing its denial of surgery. He cites Georgia-Pacific v. Piwowar, 305 Or 494 (1988), which requires us to consider the scope of the insurer's original acceptance. Here, there is a 1502 form which refers to the original 801 that claimant signed. There are no boxes checked on the 801. The record does not contain anything to indicate the scope of the original acceptance. Thus, Piwowar does not apply.

However, when we consider the full scope of the information available to the insurer before accepting the claim, we find that it had, in its possession, sufficient medical information relating to claimant's injury so as not to believe that it was accepting a claim for all problems that might arise with claimant's "entire body, except head." In any event, it is clear that the insurer has expressly denied responsibility for claimant's low back surgery. Such a specific denial is permissible. See Stratis v. Georgia-Pacific Corp., 96 Or App 706 (1989); Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989). See also Johnson v. Spectra Physics, 303 Or 49 (1987) (partial denial allowed if insurer specifically states what is denied).

ORDER

The Referee's order, dated September 4, 1987, is affirmed. A client-paid fee, not to exceed $790, is approved.

VAN M. GIBSON, Claimant — WCB 86-03187
Garry L. Kahn, Claimant's Attorney — December 1, 1989
Davis, Bostwick, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Nichols, Brittingham and Crider.

The insurer requests review of Referee Menashe's order which set aside its denial of claimant's knee injury claim. We reverse.

ISSUES

The primary issue is whether claimant is a subject worker of an Oregon employer.

The insurer also contends that the Referee erred in admitting into evidence documents submitted late.

Finally, the insurer contends that if the Referee was correct in finding claimant an Oregon worker, claimant has failed to prove that his knee surgery was caused by his December 16, 1985 injury.

FINDINGS OF FACT

Claimant began driving long haul trucks for Diamond Western (Diamond) in July 1985. Claimant was paid mileage plus expenses and a fee for every pickup and delivery. Claimant had previously worked for companies owned by Diamond's owner. In late 1985, claimant delivered four loads of Christmas trees to Tim Mitchell Christmas Trees (Mitchell) in Phoenix, Arizona. After the fourth load, claimant rested one day and then "milled around" Mitchell's Phoenix tree lot. Claimant helped Mitchell sell some trees that day. Mitchell asked claimant if he would

like to do some local deliveries for him. Claimant checked with his dispatcher at Diamond who indicated he had no other work for him at that time. Claimant then began hauling trees to Mitchell's outlying lots. Claimant knew that his deliveries were in support of Mitchell's business interests. Mitchell controlled where claimant would pick-up and deliver trees, what trees would be hauled and when claimant would haul those trees. Claimant injured his knee on December 16, 1985 during one of those deliveries.

The owner of Diamond, Clayton Robinson, and Tim Mitchell were personal friends. Robinson's son is married to Mitchell's daughter. Claimant is Robinson's son-in-law. For a number of years employes of Robinson's trucking companies have regularly delivered trees to Mitchell's lot in Phoenix and then done work to help Mitchell's Christmas tree business. Claimant, himself, has done so two to four times.

In November 1985, claimant drove to the east coast and southern United States delivering Christmas supplies for Mitchell and picking up supplies needed by Mitchell. Mitchell's son-in-law accompanied claimant on that trip.

On both his trip to the east coast and the local deliveries claimant made in Arizona, he drove Diamond's truck. Diamond paid claimant in the normal manner for all the work he did on Mitchell's behalf. Diamond paid for the gasoline used in the deliveries made on Mitchell's behalf.

Claimant went to the emergency room when he injured his knee on December 16, 1985. At the emergency room, he listed Diamond as his employer on the workers' compensation claim form.

Claimant returned to Oregon with another Diamond driver on December 21, 1985. Claimant made another trip for Diamond after Christmas.

While claimant was dancing in January 1986, his knee locked up so that he was completely unable to move it. Dr. Hardiman performed surgery for a bucket-handle tear of the medial meniscus. The injury in Arizona is a material cause of the need for this surgery.

After claimant returned to Oregon following his surgery, Robinson told him to file the claim for the Arizona injury against Mitchell because Robinson did not want another workers' compensation claim against Diamond. Claimant did so on January 27, 1986. The claim was accepted by Mitchell's Arizona insurer. The Arizona insurer paid time loss and medical benefits. Claimant also filed an injury claim with Diamond, which it denied on February 11, 1986. Claimant requested a hearing on the denial.

On April 9, 1987, the insurer moved to dismiss the request for hearing. The appendix to the motion contained a copy of claimant's request for hearing, the insurer's denial, and a copy of a notice of claim status from Arizona. Claimant responded to the motion on April 10, 1987. Appended to the response was the denial, claimant's trip reports, a payroll recap and an advisory letter from the Workers' Compensation Department. The Referee denied the motion to dismiss on April 14, 1987. On that same date, claimant submitted exhibits 1 through 7 for inclusion into

the record. Portions of exhibit 1, as well as exhibit 2, exhibit 6, and exhibit 7, had previously been submitted as appendices to the motion and response.

The hearing took place on April 21, 1987. At hearing, the insurer objected to receipt of exhibits 1 through 7 on the basis of the then existing administrative rule which required claimant to submit his exhibits within 10 days of the hearing. The Referee admitted the exhibits, but did not make a finding of good cause as required by the rule in effect at that time. He did find that there was no prejudice to the insurer. He also noted that, under the usual practice, the insurer normally submits the first exhibit packet, but did not do so in this case. In light of the insurer's "gamesmanship," the Referee did not allow the insurer's objection to the offered exhibits.

After the hearing, claimant submitted additional exhibits which were received without objection. The insurer also submitted additional exhibits which were received over claimant's objection.

CONCLUSIONS AND OPINION

Evidentiary Ruling

The Referee erred in admitting the exhibits which were submitted late without making a finding of good cause. However, on de novo review we find that claimant had good cause for the late submission. Because of the insurer's motion to dismiss, it was possible that there would not even be a hearing. That complication, together with the insurer's failure to submit any exhibits despite the normal practice in this forum, combine to create good cause for claimant's late submission. Furthermore, the Referee cured any possible prejudice to the employer by allowing both parties to submit additional evidence after the hearing. Accordingly, the contested exhibits remain part of the record.

Subject Worker

The Referee concluded that claimant remained in Diamond's employ while in Arizona. He also concluded that the fact that a claim was accepted in Arizona against Mitchell does not bar claimant from recovering from Diamond under Oregon's Workers' Compensation Law. We disagree.

ORS 656.023 defines subject employers as employers employing one or more subject workers. ORS 656.027 defines subject workers as all workers except those specifically exempted under that provision. Workers compensated under federal compensation acts are exempt; however, there is no specific exemption for workers also covered under the compensation acts of Oregon's sister states. Diamond was, therefore, clearly a subject employer. Consequently, if claimant was in Diamond's employ when he was injured in Arizona, he has a compensable claim against Diamond.

The insurer argues that claimant was Mitchell's employee and not Diamond's employee when the injury occurred. It contends that there was an implied contract for hire between claimant and Mitchell, and that Mitchell exercised control over claimant; consequently, it asserts that claimant was Mitchell's employee.

We find the loaned-servant doctrine useful in deciding whether, under Oregon law, Diamond should be relieved of liability for claimant's workers' compensation claim against it. We conclude that under the loaned-servant doctrine claimant was Mitchell's employee, and not Diamond's, at the time of his injury, so that Diamond is relieved of liability.

Application of the loaned-servant doctrine requires the following analysis. First, the finder of fact must determine if the worker was loaned by the general employer to the special employer. If he was, then the finder of fact must determine whether the work being done was essentially that of the special employer. Finally, the finder of fact must determine whether claimant was an employee of the special employer. Newport Seafood v. Shine, 71 Or App 119, 123 (1984); Multnomah County v. Hunter, 34 Or App 718, 721 (1981); 1C Larson, Workmen's Compensation Law 8-405, sec. 48.00 (1986). The basic test for determining an employment relationship for workers' compensation purposes consists of two elements: 1) the existence of a contract for hire; and 2) the employer's right to control. Keith A. Shine, 35 Van Natta 1865, 1866, quoted with approval, Newport Seafood v. Shine, supra at 123.

Here, the course of conduct between Robinson and Mitchell persuades us that Robinson was in the habit of lending Mitchell workers during the Christmas season. In this instance, Diamond loaned claimant to Mitchell. Furthermore, there is no question that claimant was essentially doing Mitchell's work. He was hauling trees between Mitchell's main lot and his outlying lots.

We turn to the existence of an employment relationship. A determination of an employment relationship in workers' compensation law focuses first on the claimant's perspective. Newport Seafood v. Shine, supra at 124. Here, Mitchell asked claimant to do the work which claimant agreed to do. Claimant expected to be paid for that work, albeit by Diamond. Claimant knew that he was working to further Mitchell's business purposes. These facts are sufficient to establish an implied contract for hire, and we so conclude.

We also conclude that Mitchell exercised control over claimant while claimant was hauling trees for Mitchell. Mitchell controlled where claimant would pick-up and deliver trees. Mitchell also controlled what trees would be picked up and when claimant would make his pick-ups and deliveries. The fact that Diamond paid claimant's wages is not sufficient to overcome the fact that Mitchell controlled claimant . See Harris v. SIAC, 191 Or 254 (1951): Multnomah County v. Hunter, supra.

In summary, Diamond loaned claimant to Mitchell; claimant was doing Mitchell's work; there was an implied contract for hire between Mitchell and claimant; and Mitchell controlled claimant. Consequently, we conclude that, at the time of injury, Mitchell was claimant's employer. Accordingly, claimant was not Diamond's employee at the time of his injury, and Diamond is not liable under Oregon law for claimant's workers' compensation claim.

ORDER

The Referee's order of September 17, 1987 is reversed. The insurer's denial, issued February 11, 1986, is reinstated.

Board Member Crider, dissenting:

The majority errs in reversing the Referee. The majority cites the proper test for determining whether claimant was employed by Diamond or by Mitchell at the time of injury. However, the majority's conclusion that an employment relationship was established between claimant and Mitchell is inconsistent with the case law.

Claimant's employment as a truck driver for Diamond was never interrupted. Throughout the trip to Arizona - including the layover period before his return to Oregon - claimant worked as a truck driver. His work could not be characterized as that of a Christmas tree vendor. He loaded, hauled and unloaded the trees. He drove a Diamond truck. He reported his activity in a Diamond log book. He checked in with his Diamond dispatcher every day or two. He was paid by Diamond. He did local hauls only with leave of his Diamond dispatcher. And he returned to Oregon at the direction of that dispatcher. In short, claimant continued to act under Diamond's authority while doing local hauls.

Despite these indicators that claimant remained Diamond's employe, the majority believes there was a contract of hire between Mitchell and claimant primarily because: 1) claimant agreed to haul at Mitchell's request; and 2) the hauling was of benefit to Mitchell.

The majority makes too much of claimant's agreement to haul; Mitchell's authority to determine pickup and delivery points and what trees would be transported; and the importance of the transport of trees to Mitchell's enterprise. It is in the nature of a common carrier's business that its deliveries are done at the request of a shipper; that the shipper designates the cargo as well as the pickup and delivery locations; and that the transport benefits the shipper's business. For this reason, Larson has noted that the presumption of continued employment by the general employer is rarely overcome in cases involving truck drivers. 1C Larson, Workmen's Compensation Law 8-470, sec. 48.23 (1986). Indeed, in this case, it could as easily be said that claimant's trip from Oregon to Arizona was made at Mitchell's insistence, pursuant to his direction, and for his benefit, as that the local hauls were made at his insistence, under his direction, and for his benefit. Therefore, we must look for direction to claimant's own understanding as to his employment status.

Claimant, when hospitalized, reported on an Arizona Industrial Commission form that his employer was Diamond. Only when instructed by Diamond personnel to file a claim in Arizona, as a Tim Mitchell employe, did he do so. The Court of Appeals has held that claimant's subjective understanding of who employs him is critical to determining whether there is a contract of employment with a special employer. Newport Seafood v. Shine, 71 Or App 119 (1984). In this case, claimant's understanding is consistent with the continuity of his work as a trucker, his continued use of Diamond equipment and his continued pay by Diamond. Therefore, there is no basis for refusing to rely on claimant's own understanding that he continued to be Diamond's employe at the time of injury.

For that reason, I dissent.

ROCHELLE M. McBRIDE, Claimant
Jolles, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-09207
December 1, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of Referee Wasley's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome and directed it to pay claimant's attorney an attorney fee of $1,200.

The Board affirms and adopts the order of the Referee with the following comment on the attorney fee issue. The Referee stated in his order that he was reducing the fee awarded claimant's attorney because of a charge incurred by the employer due to the late cancellation of a deposition by claimant's attorney. The Referee erred in considering this late charge in setting the amount of claimant's attorney's fee. No statute or rule authorizes reduction of a fee on such a basis. We nonetheless conclude that the $1,200 fee assessed by the Referee is adequate for the services rendered at hearing by claimant's attorney in this case.

ORDER

The Referee's order, dated December 31, 1987, is affirmed. Claimant's attorney is awarded $600 for services on Board review concerning the compensability issue, to be paid by the self-insured employer. A client-paid fee of up to $1,038 is approved.

SUSAN K. MEYER, Claimant
Rasmussen & Henry, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 87-14182
December 1, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Gruber's order that: (1) set aside the insurer's "de facto" denial of claimant's claim for chiropractic treatment; and (2) assessed a penalty and associated attorney fee for allegedly untimely claims processing. We reverse.

ISSUES

1. Medical Services. Whether claimant has established that her need for chiropractic care is causally related to her March 1982 compensable low back injury.

2. Penalties and attorney fees for failure to accept or deny within 60 days.

FINDINGS OF FACT

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

Claimant's back condition has remained unchanged since the September 15, 1986 Disputed Claim Settlement.

CONCLUSIONS OF LAW AND OPINION

Medical Services

Pursuant to the September 15, 1986 Disputed Claim Settlement, the insurer's denial of claimant's then-current condition was upheld. Therefore, it is the law of the case that claimant's back condition as it existed on September 15, 1986 was not compensable. Consequently, in order to establish that her present back condition requiring medical treatment is compensably related to her accepted injury, claimant must prove by a preponderance of the evidence that her current condition is different, or changed, from her noncompensable condition of September 1986.

The record does not persuade us that claimant's current back condition is different from the back condition which was disputed and settled in September 1986. To the contrary, claimant testified that, subject to variation in intensity, her symptoms have been the same and in the same place since the compensable injury. Similarly, her treating chiropractor, Dr. Khalsa, testified that claimant's symptomatology has remained unchanged throughout the period that he has treated her. Moreover, as noted by the Referee, claimant has received treatment almost continuously since she resumed treating with Dr. Khalsa prior to September 1986.

We conclude, therefore, that claimant's current condition is the same as that settled and determined to be noncompensable in September 1986. Consequently, pursuant to the September 1986 Disputed Claim Settlement, her need for treatment of her current condition is not compensably related to her accepted injury.

Penalties and Attorney Fees

Unreasonable failure to timely accept or deny claims may result in the assessment of a penalty and related attorney fee. ORS 656.262(10). The Referee concluded in this regard that the insurer had unreasonably failed to accept or deny certain of Dr. Khalsa's billings within 60 days of receipt. We agree. However, a penalty is awardable only when there are amounts "then due" upon which to assess the penalty. Id. Here, pursuant to our decision denying the compensability of the medical service bills, there are no amounts "then due" upon which to base a penalty. Consequently, no penalty may be assessed. Similarly, a penalty-related attorney fee is awardable only where the insurer unreasonably resists the payment of compensation. ORS 656.382. We have concluded that the chiropractic bills were not compensable. Consequently, the delay in accepting or denying the billings did not delay any compensation and was, therefore, not an unreasonable resistance to the payment of compensation. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989). No attorney fee may be assessed.

ORDER

The Referee's order, dated February 18, 1988, is reversed. The insurer's "de facto" denial of claimant's chiropractic treatments is upheld. The Board approves a client-paid fee, not to exceed $1,103.50.

MICHAEL W. MUIR, Claimant
Cash R. Perrine, Claimant's Attorney
Davis, et al., Defense Attorneys

WCB 86-08188
December 1, 1989
Order on Review

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Gruber's order that: (1) upheld the insurer's "de facto" denial of his aggravation claim for neck and upper back conditions; and (2) declined to award interim compensation. The insurer cross-requests review, contending that the Referee erred in assessing an attorney fee for its failure to formally accept or deny the claim. On review, the issues are aggravation, interim compensation, and the assessment of an attorney fee.

We affirm on the aggravation and interim compensation issues, but reverse on the attorney fee issue.

FINDINGS OF FACTS

We adopt the Referee's findings and make the following additional findings.

Claimant's neck and upper back conditions did not worsen and he did not become less able to work after the November 19, 1981, stipulation.

Although the insurer unreasonably failed to issue a formal acceptance or denial of claimant's aggravation claim, it did not unreasonably resist the payment of compensation.

CONCLUSIONS OF LAW

The Board adopts the Referee's "CONCLUSION AND REASONING," save for that portion of his order at page 6 pertaining to the "Failure to Accept or Deny in a Timely Manner."

Subsequent to the issuance of the Referee's order, the Supreme Court issued its decision in Ellis v. McCall Insulation, 308 Or 74 (1989); see also Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989). In Ellis the Court reasoned that there must be an unreasonable resistance to the payment of compensation as required by ORS 656.382, before an attorney fee can be assessed under ORS 656.262(10). 308 Or at 78. Accordingly, while the Referee in the case at bar correctly awarded an attorney under the law in effect at the the time of his Opinion and Order, see Mischel v. Portland General Electric, 89 Or App 140 (1987) and Spivey v. SAIF, 79 Or 568 (1986), we review the Referee's order in the light of Ellis.

Here, claimant has not prevailed to date on either the issue of aggravation or interim compensation. Despite the insurer's failure to issue a formal acceptance or denial of his aggravation claim, on this record, it did not unreasonably resist the payment of compensation. Accordingly, pursuant to Ellis, we are unable to assess an attorney fee under ORS 656.382.

ORDER

The Referee's order, dated September 9, 1987, as reconsidered October 6, 1987, is affirmed in part and reversed in part. Those portions of the order that upheld the insurer's

aggravation denial and declined to award interim compensation, are affirmed. That portion of the order that awarded an assessed attorney fee, is reversed. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $897.

FRANKLIN BROWN, Claimant
Popick & Merkel, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-13871
December 4, 1989
Order on Review

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Schultz's order, which upheld the insurer's denial of his current chiropractic treatments on three specific dates. The issue on review is whether those chiropractic treatments were reasonable and necessary treatments for the effects of the compensable injury. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in July 1985. He sought treatment from Dr. Ferrante, chiropractor, who diagnosed a lumbar strain/sprain with myofacitis. A subsequent CT scan revealed a herniated L5-S1 disc with nerve root impingement. Dr. Ferrante took claimant off work and began conservative treatment three times per week.

In May 1986, the insurer denied continuing chiropractic treatment on the basis that it was neither reasonable nor necessary. In August 1986, the claim was closed by Determination Order which awarded claimant 15 percent unscheduled permanent disability. Following this, claimant requested a hearing on the May 1986 denial as well as the August 1986 Determination Order.

In April 1987, a Referee set aside the insurer's denial of chiropractic treatment and also increased claimant's unscheduled permanent disability award to 25 percent. The insurer appealed that portion of the order which set aside its denial. On August 12, 1987, the insurer issued a denial of claimant's current chiropractic treatments received on April 8, May 6, and June 12, 1987.

In March 1988, the Workers' Compensation Board issued an Order on Review which reversed the first Referee and upheld the insurer's May, 1986, denial of chiropractic treatment. This order was appealed to the Court of Appeals which affirmed the Board without opinion. Brown v. United Grocers, Inc., 93 Or App 780 (1988).

Following the August 12, 1987 denial, claimant stopped treating with Dr. Ferrante. Prior to the treatments in April, May and June, he was on a treatment regimen of two times per month. The treatments consisted of adjustments, cold packs, and electrical stimulation. As of the date of hearing, claimant had been working for three months as a computer instructor.

FINDINGS OF ULTIMATE FACT

The current chiropractic treatments at issue were not reasonable and necessary treatment for claimant's 1985 compensable injury.

CONCLUSIONS OF LAW

The Referee concluded that chiropractic treatment was neither reasonable nor necessary and upheld the insurer's denial. We agree.

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." ORS 656.245(1). Medical expenses are compensable provided that they are reasonably and necessarily incurred in the treatment of the compensable injury. McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant bears the burden of establishing that the treatment is reasonable and necessary.

Dr. Ferrante, claimant's treating chiropractor opines that the treatment is reasonable and necessary based on the nature and extent of claimant's injury. His opinion, however, is not supported by any clinical signs or symptoms, subjective complaints or diagnostic testings. Further, Dr. Ferrante gives no objective evidence which indicates that claimant has received any material benefit, of either a palliative or curative nature, from his treatment.

Moreover, Dr. Fabricius, chiropractor, opined that claimant's ongoing chiropractic care was not reasonable or necessary. She explained that there were no objective findings to substantiate claimant's complaints. Dr. Langston, orthopedist, opined that further chiropractic care was counterproductive and noted that there was no objective basis for claimant's complaints.

We are persuaded by the well-reasoned opinions of Drs. Fabricius and Langston. In relying on their opinions, we note that their conclusions are supported by earlier opinions of Drs. Puziss and Gripekoven, who reported in 1986 that further chiropractic care was not reasonable or necessary as it offered only temporary relief and claimant had become dependent upon such treatment. Accordingly, we conclude that the chiropractic treatments in question were not reasonable and necessary as a result of claimant's 1985 compensable back injury.

ORDER

The Referee's order dated June 23, 1988, is affirmed. A client-paid fee, not to exceed $2,724.25, is approved.

DONNA M. DAVIS, Claimant	WCB 87-02612
W.D. Bates, Jr., Claimant's Attorney	December 4, 1989
Schwabe, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Garaventa's order that upheld the insurer's denial of claimant's occupational disease and/or injury claim for a right hip stress fracture. The issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the insured, a small grocery store, in May 1986. She worked the afternoon and evening shift,

primarily as a cashier. However, she was also required to restock goods and to perform cleaning chores such as mopping the floor. She was often the only employee on duty during her shift.

Claimant's work activity included repetitive strenuous bending and lifting. The heaviest work she performed was restocking milk in the cooler. Milk could be restocked one gallon at a time, but there was not always enough time to do so. She sometimes was required to lift 50 pound, six-gallon crates of milk. During her shift, claimant would need to restock milk from two to ten times. In addition, she lifted the mop bucket once per shift. This weighed between 20 and 30 pounds. She also restocked cases of beer and pop weighing up to 18 pounds. She would sometimes carry several cases at once. The employee who worked the shift prior to claimant's shift rarely, if ever, restocked the supply of beer. Claimant's shift was particularly busy because many workers in the community would shop in the evening immediately after leaving work.

On or about October 13, 1986, claimant experienced the onset of right thigh pain. She continued to work the following two days, during which time the pain gradually worsened. The next two days, October 16 and 17, were her scheduled days off work. On the evening of the 17th, claimant and her boyfriend went for a drive. Car trouble forced them to walk approximately one-half mile. When claimant reported for work the following morning, October 18, her symptoms were worse. Shortly after arriving for work, her employer insisted she receive medical assistance.

Claimant had experienced no thigh pain prior to October 13, 1986.

X-rays exposed on October 20, 1986 were interpreted as negative for stress fracture.

Claimant was off work due to her symptoms for the next week. When she returned to work after her week off, her symptoms continued unabated. In early November 1986, her treating physician, Dr. Ross, referred her to Dr. Lundsgaard, orthopedic surgeon. Repeat x-rays at this time disclosed a stress fracture of claimant's right hip. Dr. Lundsgaard subsequently performed a right hip pinning for stabilization of the fracture.

FINDINGS OF ULTIMATE FACT

The onset of claimant's stress fracture occurred on or about October 13, 1986. The fracture resulted from accumulated stress placed upon her hip over an extended period of time. Claimant's one-half mile walk on October 17, 1986 neither caused nor contributed to the cause of claimant's stress fracture. Claimant's work activities and exposures were the major cause of her stress fracture.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that her condition is compensable as either an occupational disease or an industrial injury. The Referee concluded that the claim was properly characterized as one for occupational disease. We agree and adopt the Referee's discussion of this issue. See also James v. SAIF, 290 Or 343 (1981) (occupational diseases are gradual in onset and not unexpected given work conditions).

The Referee next stated that, to prevail, claimant must establish that her work activities were not substantially the same as those encountered off the job, and that her work activities were the major cause of her stress fracture. We agree with the Referee's latter statement with regard to the quantum of work contribution necessary to establish proof of a compensable occupational disease under former ORS 656.802(1). See Dethlefs v. Hyster Co., 295 Or 298 (1983) (requiring proof that claimant's work exposure is major cause of disease).

However, we do not agree with the requirement stated by the Referee that claimant's work activities be "not substantially the same" as her off-work activities. This approach was rejected by the Court in Dethlefs, supra. The Court stated in Dethlefs that, if a disease is caused by an exposure of a type to which a claimant is exposed both on and off the job, then one must "look either to the degree or to the quantum of stress on the job as compared to off the job to resolve the issue of compensability." Id. at 308. Thus, there is no requirement that the type of activities or exposures encountered at work be different from those encountered off work. Instead, the appropriate inquiry is to the quantum of exposure on and off the job.

Claimant contends that the physical stress of her work, in particular her lifting activities, was the major cause of her stress fracture. Several physicians have addressed this causation question. Dr. Struckman, orthopedic surgeon, examined claimant at the insurer's request on January 9, 1987. We attach considerable weight to Dr. Struckman's ensuing report. After recounting claimant's history of the onset of right hip pain following strenuous bending and lifting at work, Dr. Struckman states that he knows of no activity other than claimant's work that would account for her stress fracture.

We are persuaded that Dr. Struckman's opinion was based on an accurate history of claimant's right hip condition and work activities. Claimant testified that she primarily rested on her days off work. She also denied any significant off-work activities. The Referee expressly found claimant to be credible based both upon demeanor and the content of her testimony. To the extent the Referee's finding is based upon demeanor, we defer to that determination. See Humphrey v. SAIF, 58 Or App 360, 363 (1982). Moreover, we find nothing in the content of claimant's testimony to cause us to question her credibility. We further note that Dr. Lundsgaard, the treating orthopedic surgeon, and Dr. Ross, the treating osteopath, both concurred with Dr. Struckman's report. We conclude that there is no evidence of any off-work activities which would account for claimant's condition. See Moore v. Douglas County, 92 Or App 255, 258 (1988). Therefore, Dr. Struckman's statement regarding the lack of other contributing factors is supported by the record.

Dr. Struckman subsequently opined that stress fractures result not only from prolonged walking but also from "repetitive and prolonged" lifting and bending. This opinion was shared by Dr. Vigeland, who performed an independent medical examination in January 1987. Dr. Vigeland opined that he would attribute claimant's stress fracture to her work if her job duties "required significant activities not normally carried out in activities of daily living." We are persuaded in this regard that her work activities both involved "repetitive and prolonged" lifting and

bending, and that those activities "required significant activities" beyond those of daily living.

During most of her shift, claimant was the sole employee in the store. In addition, her shift was the busiest of the day. While claimant was provided with various mechanical aides to assist her in her lifting and carrying activities, neither she nor her co-workers utilized these aides to any great extent. Moreover, while fellow employee Ferguson initially stated that the job duties at the store were no more strenuous than those of cleaning a house, she subsequently agreed that claimant, as a result of the shift she worked, was required to spend more time restocking milk and beer than Ferguson was required to do during the earlier shift.

Finally, we place some importance upon Dr. Lundsgaard's reluctance to agree with Dr. Vigeland's January 9, 1987 report. While Dr. Lundsgaard concurred with much of Dr. Vigeland's report, he wrote a separate letter expressly to state his disagreement with Vigeland's discussion regarding causation. He apparently interpreted Dr. Vigeland's report as weighing against the work-relatedness of claimant's fracture. In response he stated:

> "There is certainly no clear-cut evidence that [claimant's] job caused her stress fracture, but * * * at this point I cannot say that her job was not responsible for the stress fracture."

Taken alone, Dr. Lundsgaard's statement would be insufficient to establish compensability of the stress fracture. However, in conjunction with Dr. Struckman's reports, as well as claimant's credible testimony regarding her work and off-work activities, we conclude that claimant has met her burden of establishing that her work exposures were the major cause of her stress fracture.

ORDER

The Referee's order, dated November 23, 1987, is reversed. The insurer's February 12, 1987 denial is set aside and the claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded an assessed fee of $2,200 for his services at hearing and on Board review, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $1,078.

MILTON D. FORELL, Claimant	WCB 87-05806
Norman Cole (SAIF), Defense Attorney	December 4, 1989
	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Smith's order that: (1) declined to grant an award of permanent total disability; (2) awarded an additional 22.5 percent (72 degrees) unscheduled permanent disability for his back condition, beyond a Determination Order award of 22.5 percent (72 degrees); (3) awarded increased temporary disability compensation; and (4) allowed an offset of previously overpaid temporary disability compensation from apparently either or both of the above awards. On review, the issues are permanent total

disability, extent of unscheduled permanent disability, temporary disability, and offset.

The Board affirms in part and modifies in part the order of the Referee.

FINDINGS OF FACT

The Board adopts the Referee's findings with the following supplementation. Claimant experienced a worsening of his injury condition in July 1986. That worsening resulted in a period of total incapacity of more that 14 consecutive days.

CONCLUSIONS OF LAW

The Board adopts the Referee's conclusions with the following modification on the offset issue.

In his order, the Referee stated that the SAIF Corporation could offset overpaid temporary disability "from the above award of benefits * * *." Yet "the above award" included both permanent and temporary disability benefits. We modify.

A Referee's authorization of an offset continues in effect until revoked or the overpayment is wholly recovered. Berliner v. Weyerhaeuser Co., 92 Or App 264 (1988). An overpayment may be recovered, however, from only permanent disability benefits; not temporary disability benefits. Buddy Tillman, 41 Van Natta 239 (1989). Given the Referee's ambiguous language concerning recovery of the overpayment, we modify his order to reflect that SAIF shall recover its overpayment (i.e, offset) from only awards of permanent disability.

ORDER

The Referee's order, dated January 15, 1988, is affirmed in part and modified in part. In lieu of the Referee's authorization of SAIF's request for an offset of overpaid temporary disability benefits, SAIF is authorized to offset its overpayment from only permanent disability awards. All remaining portions of the Referee's order are affirmed.

WILLIAM E. HAMILTON, Claimant	WCB 87-05125
David Force, Claimant's Attorney	December 4, 1989
Kate Donnelly (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Blevins' order which: (1) found that his low back claim was not prematurely closed; and (2) awarded a carrier-paid attorney fee of $500. Claimant contends that the attorney fee award should be increased. The SAIF Corporation cross-requests review of those portions of the order which: (1) affirmed a Determination Order medically stationary date; (2) increased claimant's unscheduled permanent disability award for a low back condition from 20 percent (64 degrees), as awarded by Determination Order, to 35 percent (112 degrees); (3) set aside its denial of medical services and awarded attorney fees; (4) awarded temporary total disability for a period during which claimant participated in a work hardening program; and (5) declined to authorize offset of

additional overpaid temporary total disability benefits against future awards of compensation. The issues on review are premature closure, temporary total disability, extent of permanent partial disability, medical services, attorney fees and offset. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Summary of Facts" with the following supplementation.

Claimant was medically stationary on December 11, 1986. His claim has not been reopened since that date.

Claimant failed to mitigate his low back problems by failing to lose weight as directed by his physicians.

Claimant received an overpayment of temporary total disability between May 11, 1987 and July 1, 1987.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

A claim may be closed if claimant's compensable condition is medically stationary, i.e., 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 establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Brad T. Gribble, 37 Van Natta 92 (1985). The resolution of the medically stationary date is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

The Evaluation Division found that claimant was medically stationary on December 11, 1986, the date his compensable weight loss program was concluded. Claimant contends that he was not medically stationary until July 1, 1987, when Dr. Schachner ended claimant's work hardening program. On the other hand, SAIF contends that claimant should have been found medically stationary on March 12, 1986, when his attending physician listed him as such.

We are not persuaded that claimant's participation in a work hardening program, commencing in May 1987, renders the Determination Order premature. When the Determination Order issued on March 3, 1987, claimant's treating physician was Dr. Schachner. He noted that there had been "very little change in [claimant's] course over the past year." Dr. Schachner's only suggestion for treatment was that claimant assume the responsibility of getting himself physically into condition. He also noted that claimant had not been successful in completing a weight loss program in the past. Under these facts, we are not persuaded that further improvement in claimant's condition could then "reasonably be expected."

Neither are we persuaded that claimant was medically stationary on March 12, 1986, as asserted by SAIF. In that regard, claimant commenced a weight loss program in February 1986. It was contemplated by claimant's physicians that a loss of

weight would greatly relieve the pain that accompanied his low back condition and allow him to reenter the work force. As of March 12, 1986, it could reasonably be expected that the continuing weight loss program would provide further improvement of claimant's condition; thus, he was not medically stationary during his participation in the program.

We conclude that claimant was medically stationary on December 11, 1986, the date established by the Determination Order.

Temporary Total Disability

SAIF argues that claimant is not entitled to temporary disability during his work hardening program. We agree.

As discussed above, we affirm the Determination Order as not having been premature. Claimant did not argue, nor did he present any evidence, that there was an aggravation of his low back injury that would require his claim to be reopened at the time of the work hardening program. Because we find that his claim was properly closed in March 1987, and because claimant has not asserted or established a compensable aggravation, claimant was entitled to no temporary disability benefits during his participation in the work hardening program. ORS 656.273(1); see Leonard Jennsen, 41 Van Natta 263, 268 (1989).

Medical Services

On March 30, 1987, SAIF issued a denial which stated in part:

> "An Opinion and Order issued on December 18, 1985 ordered SAIF Corporation to authorize a weight loss program for you persuant [sic] to the prescription written by Dr. Bert. Information in your file indicates that you have failed to cooperate in that weight loss program on numerous occasions. Therefore, without waiving further questions of compensability, we must deny your claim for benefits. SAIF will continue to make medical payments related to your original injury. . . ."

The Referee found that this denial referred to both a weight loss program and a work hardening program allegedly prescribed by Dr. Schachner on or near March 25, 1987. The Referee further concluded that the proposed treatment was compensable.

In his opening statements at hearing, claimant alleged, despite the last quoted sentence of SAIF's denial, that it was a purely prospective denial of all medical services for claimant's compensable condition (Tr. 4, 5). SAIF did not refer to the denial in its opening statements.

In written closing arguments, claimant changed his tact. At one point he argued that SAIF's March 30, 1987 denial was a denial of an evaluation at a pain center prescribed by claimant's earlier treating physician on June 17, 1986. (Closing arguments at 4, 7). At another point, he argued that SAIF's denial was of a weight loss program and any future medical treatment. (Closing arguments at 6). At still another point,

claimant argued that the denial was of the June 17, 1986 request for pain center evaluation, "physical therapy and physical restorative services" prescribed by Dr. Schachner in 1987, and of a weight loss program previously provided claimant. (Closing arguments at 11). Finally, claimant argued that the March 30, 1987 denial was of a "weight loss program suggested by Dr. Schachner" and of a CT scan. (Closing arguments at 21).

SAIF, in its closing arguments, argued that the March 30, 1987 denial was of the weight loss program authorized pursuant to a December 1985 Opinion and Order, and from which claimant had already been terminated. (Closing arguments at 1, 22, 50-51).

We do not agree that SAIF's denial referred to the work hardening program. Although Dr. Schachner's chart note of March 25, 1987 (Ex. 114-2) mentioned the possibility of such a program, it is clear that May 11, 1987 was the actual date the doctor first prescribed the program (Exs. 114-2; 127). Neither do we find in the record any claim for a weight loss program, pain center evaluation, or CT scan pending on March 30, 1987, when SAIF issued its denial.

We find that the record demonstrates no "claim" which required acceptance or denial. Thus, we conclude that SAIF's March 30, 1987 denial was a nullity and must be set aside. James C. Conaway, 41 Van Natta 2033 (November 9, 1989); Alvin H. Despain, 40 Van Natta 1823 (1988).

The Referee awarded claimant's counsel an attorney fee of $500 for successfully overcoming SAIF's denial of the claim for the work hardening program. While we do not reach the same conclusion, we find claimant's attorney entitled to such fee for obtaining reversal of SAIF's denial of "benefits". James C. Conaway, supra.

Extent of Permanent Disability

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Claimant was 38-years-old at the time of the hearing. He received a formal education through high school. His prior work experiences have all been sawmill related, limited to heavy manual labor. Claimant has undergone two surgeries. His second physician, Dr. Bert, released claimant to light/moderate work following those surgeries.

The Referee found that claimant's obesity has interfered with recovery from his injury. His weight loss program was a compensable medical service which claimant did not take advantage of. Both physicians with whom claimant treated suggested and prescribed weight loss and/or work hardening programs which claimant did not complete. SAIF has demonstrated that claimant

unreasonably failed to follow a weight reduction plan. See Nelson v. EBI Companies, 296 Or 246, 252 (1984).

After reviewing the medical and lay evidence, and considering the relevant social and vocational factors, including the fact that claimant did not mitigate his medical problem by completing a weight loss program, we conclude that a total award of 20 percent unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity.

Offset

SAIF requests authorization to offset temporary disability benefits ordered paid by the Referee for the period claimant was enrolled in the work hardening program. We have concluded above that claimant is not substantively entitled to such benefits. Nevertheless, the temporary benefits were paid pending appeal and, therefore, they are not recoverable by offset. ORS 656.313(2); Weyerhaeuser v. McCullough, 92 Or App 204 (1988).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review pertaining to the issue of SAIF's March 30, 1987 denial. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated March 25, 1988 is reversed in part and affirmed in part. That portion of the Referee's order that awarded increased permanent disability beyond that awarded by Determination Order and an out-of-compensation attorney fee is reversed. The Determination Order award of 20 percent (64 degrees) unscheduled permanent disability is reinstated and affirmed. The award of temporary total disability and an out-of-compensation attorney fee for the period claimant was in the work hardening program is reversed. The remainder of the Referee's order is affirmed.

ARNOLD R. JOHNSON, Claimant

Own Motion 87-0654M
December 4, 1989
Own Motion Order

The Board issued its Own Motion Order in the above-entitled matter on December 11, 1987, reopening claimant's claim for a worsened condition related to his industrial injury of November 22, 1977. The claim has now been submitted for closure.

The Board reopened claimant's claim with temporary disability benefits commencing on November 17, 1987. The record shows that claimant entered an authorized training program (ATP) with the vocational objective of Traffic and Sales Coordinator on January 30, 1989. Claimant was not yet medically stationary when he entered training.

In cases where a claim is reopened under the Board's "own

motion" authority and the worker enters an ATP prior to becoming medically stationary, it is the Board's policy to refer the claim to the Evaluation Section for closure and determination of permanent disability when the ATP ceases and claimant becomes medically stationary. See former ORS 656.268(4), (5). Here, the training program ended on April 7, 1989.

Accordingly, the insurer shall submit claimant's claim with all relevant medical and vocational reports to the Evaluation Section for closure and determination of permanent disability. The insurer shall continue to pay claimant temporary disability benefits until claim closure, unless unilateral termination of benefits is permitted by law. Therefore, the request for Board closure is denied.

IT IS SO ORDERED.

CLARENCE C. NOON, Claimant — WCB 86-07367
William B. Wyllie, Claimant's Attorney — December 4, 1989
Thomas M. Sheridan (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Howe's order that upheld the SAIF Corporation's denial of his myocardial infarction. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

We adopt paragraphs one through six of the Referee's "facts" section with the following supplementation.

Prior to claimant's myocardial infarction, he smoked two packs of cigarettes per day for approximately 20 years. He also had a high cholesterol level, and suffered from arteriosclerosis, or coronary artery disease.

Claimant's DUII conviction on January 3, 1986 did not cause claimant any significant emotional distress. He pleaded guilty and was put through a diversion program.

The cost overrun of the job claimant was working on at the time of the myocardial infarction, along with the accident suffered by another employee under claimant's supervision, placed claimant under a significant amount of emotional stress. In fact, the on-the-job emotional stress was a material contributing cause of claimant's myocardial infarction.

CONCLUSIONS OF LAW

The Referee believed that Dr. Toren's opinion was based on more reliable and extensive information than the opinion offered by Dr. Turner. Accordingly, he found claimant's claim not compensable. We disagree.

To establish a compensable heart condition, a claimant must prove that the work activity was both the legal and medical cause of the condition. Somers v. SAIF, 77 Or App 259, 262 (1986), citing Bush v. SAIF, 68 Or App 230, 232 (1984). Legal causation, in cases of emotional stress, can be established by a showing of chronic emotional stress or an episode of acute stress. Harris v. Farmers' Co-op Creamery, 53 Or App 618 rev den 291 Or 893 (1981). The medical causation question is whether the stress was, within

reasonable medical probability, a material contributing cause of the infarction. Coday v. Willamette Tug & Barge, 250 Or 39, 47 (1968). Adams v. Gilbert Tow Service, 69 Or App 318, 321 (1984).

Dr. Turner was claimant's treating physician. She saw him from the date of the myocardial infarction until April 1986. Although she was not a cardiologist, but rather an internist, 50 percent of her hospital practice was in cardiology.

Dr. Turner's opinion regarding causation was based on a history of the extreme pressure claimant was feeling as a result of the cost overrun of the job, and the sense of responsibility he took upon himself for the accident to the employee under his supervision. Although she was unaware of the DUII arrest until her testimony, she persuasively held that her opinion, that claimant's myocardial infarction was caused in material part by work stress, remained unchanged. She did not change her opinion because: (1) claimant had experienced angina the day before the DUII arrest; and (2) the myocardial infarction did not occur until claimant was back on the job the day after the DUII arrest.

Dr. Turner explained that the biological cause of claimant's heart attack involved the activity of platelets, the clotting elements in the blood. She stated that Norepinephrine, a stress hormone produced by the adrenal cortex, causes platelets to become stickier and thereby clot more efficiently. (Tr. 10). She also stated that Norepinephrine causes the heart to beat faster and the blood pressure to rise. She maintained that the production of Norepinephrine is directly linked to the level of stress. (Tr. 11). In claimant's situation, Dr. Turner opined that the intense stress from the job pressures caused the increased production of Norepinephrine, thereby initiating an aggregation of platelets, which in turn led to an acute thrombosis and the myocardial infarction. (Ex. 8).

Dr. Toren, a cardiologist, examined claimant on one occasion and offered a contrary opinion. He believed that the major factors in the development of claimant's coronary artery disease were cigarette smoking and elevated cholesterol. He explained the process of thrombus formation as follows:

> "[Thrombus formation] occur[s] when this long-standing plaque develops a crack along its inner lining. The crack develops as part of the scarring process which is the hallmark of arteriosclerosis. Once the plaque cracks, blood flowing over this cracked plaque is stimulated to clot because of the exposure to collagen and other materials within the wall of the plaque. The blood is normally prevented from this contact by the smooth inner lining of the artery. This cracking of the plaque with subsequent thrombus formation has not been shown to be associated with physical exertion, emotional stress, worry, or excitement. It is my considered opinion, then that this transmural myocardial infarction occurred as part of the natural progression of his underlying coronary artery disease. His occupational

exposure would not have contributed to either a temporary or permanent worsening of his coronary artery disease."

Although Dr. Toren's opinion regarding plaque formation was detailed, it did not address the effect which emotional stress has on the production of Norepinephrine and the consequences of increased clotting activity in an already diseased coronary artery. In this regard, we find the opinion of Dr. Turner to be more convincing. Therefore, we find no persuasive reason why we should not defer to the opinion of claimant's treating physician.

Claimant has successfully proven legal causation by a showing of chronic emotional work-related stress, and an episode of acute stress resulting from the accident to the worker under his supervision. Claimant has also proven medical causation by showing that the stress was, within reasonable medical probability, a material contributing cause of the myocardial infarction.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid fee for services rendered at hearing and on Board review. Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order, dated October 28, 1987, is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law.

CHARLES R. PALMER, Claimant	WCB 85-11024
Francesconi & Associates, Claimant's Attorneys	December 4, 1989
Rankin, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of Referee Heitkemper's order which: (1) set aside its denials of claimant's acupuncture treatment and psychological treatment; and (2) increased claimant's unscheduled permanent disability award for his stress condition from 10 percent (32 degrees) as awarded by a Determination Order, to 25 percent (80 degrees). The issues on review are compensability and extent of permanent disability. We afffirm.

FINDINGS OF FACT

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

Claimant's back injury claim was closed by the December 29, 1983 Determination Order.

The employer, on September 4, 1985, denied "any further acupuncture treatment." On November 12, 1987, it denied claimant's "ongoing care by Dr. Colistro," his psychologist.

FINDING OF ULTIMATE FACT

The employer's September 4, 1985, and November 12, 1987 denials prospectively denied future medical services.

CONCLUSIONS OF LAW AND OPINION

We adopt that portion of the Referee's opinion which addresses the issues of extent of disability.

The Referee found the medical services reasonable and necessary. We affirm the Referee's order setting aside the employer's denials but on the basis that the denials were procedurally improper prospective denials.

The employer's denials of September 4, 1985 and November 12, 1987 are entirely prospective in nature. Neither denial is addressed to medical services already rendered. They each deny only future medical benefits. As written, the denials are procedurally improper. An employer cannot deny treatment prospectively. ORS 656.245; Robert M. Bryant, 41 Van Natta 324 (1989). This is true regardless of whether the underlying claims had been closed. See Evanite Fiber Corp. v. Striplin, 99 Or App 353 (November 8, 1989); Bowser v. Evans Product Company, 270 OR 841 (1974).

Claimant's counsel is statutorily entitled to a reasonable, assessed attorney fee for services rendered on Board review. However, because no statement of services has been received to date, we are presently unable to award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order dated May 24, 1988, is affirmed. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $1,977.

RONALD D. REYNOLDS, Claimant
JAMES R. BREWER, dba,
JIM BREWER POSTS & POLES, Employer
Stephen Finlayson, Claimant's Attorney
Cramer & Cramer, Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-15926
December 4, 1989
Order of Dismissal

Reviewed by Board Members Perry and Howell.

James R. Brewer, the alleged noncomplying employer, requests review of Referee Wasley's order which affirmed the order of the Workers' Compensation Department finding that the employer was a noncomplying employer. We dismiss the request for review for lack of jurisdiction.

FINDINGS OF FACT

On October 26, 1986, the Director issued a Notice of Proposed and Final Order declaring that James R. Brewer was doing business as a sole proprietorship, which was a noncomplying employer. On November 11, 1986, the employer requested a hearing on the Notice of Proposed and Final Order. By letter dated November 12, 1986, the SAIF Corporation informed the employer that claimant's claim had been accepted. At the employer's request, a hearing was held before the Referee contesting the Director's proposed order of noncompliance. Evidence was admitted on the issue of noncompliance. Thereafter, the Referee affirmed the Director's proposed order. The Referee's order concludes in part:

"NOTICE TO ALL PARTIES: If you are dissatisfied with this Order, you may, within thirty (30) days after the mailing date of this Order, request a review by the Worker's Compensation Board . . ."

CONCLUSIONS OF LAW

If any party requests a hearing on a Director's proposed order regarding noncompliance or any other matter unrelated to a claim, the Board appoints a Referee to hold a hearing. ORS 656.283(4); Heinz J. U. Sauerbrey, 37 Van Natta 1512 (1985). That is the Board's only involvement in cases such as this. When a Referee issues an order, it is then a final order of the Director and must be appealed directly to the Court of Appeals. ORS 183.480 (1), (2); see Stanley Wilson, 40 Van Natta 387 (1988).

Although the Referee discussed SAIF's acceptance of claimant's claim, the employer's request for hearing related solely to the issue of noncompliance. Moreover, at hearing, the employer framed the issue as an objection to the noncompliance order. Inasmuch as SAIF's acceptance of the claim was not at issue, the Referee's discussion of the acceptance was gratuitous. Because the Referee's order solely concerned the noncompliance order, the Board does not have jurisdiction over the employer's request for review. Since we lack jurisdiction to review the Referee's order, the appeal must be dismissed.

It is regrettable that the Referee's statement of appeal rights may have misled the parties. However, our jurisdiction is statutory and an incorrect statement of appeal rights cannot expand or contract that jurisdiction. See Gary O. Soderstrom, 35 Van Natta 1710 (1983).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

BILLY J. RUCKER, Claimant
Vick & Gutzler, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-16538
December 4, 1989
Order on Review (Remanding)

Reviewed by Board Members Gerner, Cushing and Myers.

Claimant requests review of Referee Borchers' order that dismissed his request for hearing. On review, the issue is whether the Referee erred in dismissing his request for hearing. We reverse and remand.

FINDINGS OF FACT

Claimant's attorney appeared at the hearing, but claimant did not. No explanation for his nonappearance was provided. Claimant's attorney did not request that he be allowed to proceed on the record. The insurer moved for a dismissal. Claimant's attorney did not oppose the insurer's motion, other than to request the Referee to issue a "Show Cause Order." The Referee issued an Order of Dismissal, dated January 8, 1989. Shortly thereafter, claimant filed a motion to abate the Referee's order and to reinstate his request for hearing. The motion was accompanied by an affidavit from claimant explaining that he neither received notice of the hearing nor knew about it.

Claimant's current mailing address has not changed since the 1982 compensable injury. The Notice of Hearing was correctly mailed to his current address and was not returned by the Postal Service as undeliverable. In addition, approximately two weeks prior to the January 5, 1988, hearing, claimant personally met with his attorney. During the course of that meeting, his attorney informed him of the date of the upcoming January 5, 1988, hearing.

On February 2, 1988, the Referee issued an order, which despite being labeled "Order on Reconsideration," declined to grant claimant's motion on the grounds that the Board's administrative rules did not allow for reinstatement of a hearing request upon a showing of good cause.

Claimant has not established extraordinary circumstances to warrant the reinstatement of his request for hearing. His failure to appear constituted a waiver of appearance and the right to testify on his own behalf.

CONCLUSIONS OF LAW

At the time of the hearing, former OAR 438-06-071 provided that a Referee shall dismiss a party's Request for Hearing if that party or his representative fail to appear at the hearing unless a postponement is granted. See WCB Admin. Order 5-1987 (December 18, 1987). A postponement was permissible only upon a finding of extraordinary circumstances beyond the control of the party requesting the postponement. Former OAR 438-06-081.

Here, claimant requested the hearing. Although his attorney personally appeared at the hearing, he did not. There was no showing of extraordinary circumstances nor a request for postponement. Accordingly, the Referee correctly dismissed his request for hearing under the law in effect at the time of the hearing.

While the Referee still retained jurisdiction, however, claimant motioned for reinstatement of his hearing request. Accompanying his motion was an affidavit explaining that he neither received notice nor had knowledge of the hearing. The Referee was incorrect to not consider claimant's motion and supporting affidavit. Nothing in former OAR 438-06-071 prevented her from doing so.

Inasmuch as claimant's motion and affidavit are part of the record presently before us, on de novo review we may consider whether he has proven extraordinary circumstances under former OAR 438-06-081. We are not persuaded that he has. His current mailing address has not changed since the date of his 1982 compensable injury. The Notice of Hearing was correctly sent to his current address and he makes no allegation to the contrary. Given those facts, and the absence of any other facts, we are not persuaded by his assertion that he did not receive notice of the hearing.

In addition, claimant asserts that he has no recollection of being told of the January 5, 1988, hearing. Yet, in his affidavit, he states: "[M]y attorney's office has indicated that it discussed this hearing with me some two weeks prior to the hearing * * *." Accordingly, we are persuaded that claimant's attorney informed him of the hearing two weeks prior to January 5, 1988.

After considering claimant's affidavit, in light of the entire record, we conclude that he has not proven extraordinary circumstances to warrant reinstatement of his request for hearing. We do not agree with the view of the dissenting opinion that we must unquestionably accept the assertions in claimant's affidavit. The fact finder is not required to believe the testimony of a witness merely because it is uncontradicted. Harwell v. Argonaut Insurance Company, 296 Or 505, 511, n. 9 (1984).

Despite our above finding, subsequent to the Referee's order, the Court of Appeals issued its opinion in Williams v. SAIF, 98 Or App 367 (1989). In Williams, the court reasoned that OAR 438-06-071 did not allow a Referee to dismiss a request for hearing when, as here, a claimant's attorney personally appears at the hearing on behalf of his absent client. In such instances, claimant's attorney has the right to proceed on the record and to present any admissible written and/or testimonial evidence. Williams, 98 Or App at 370.

Accordingly, in the light of Williams, we remand to a Referee to take evidence other than that of claimant's testimony. This may be done in any manner that will achieve substantial justice and that is acceptable to the parties and the Referee. Inasmuch as the Referee who initially heard this matter is no longer available, the Presiding Referee is directed to assign this case to a Referee.

ORDER

The Referee's order dated January 8, 1988, as reconsidered on February 2, 1988, is vacated and this matter is remanded to a Referee, to be assigned by the Presiding Referee, to carry out the instructions consistent with this order. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $648.

Board Member Myers, dissenting.

I respectfully dissent from that portion of the majority's opinion which holds that claimant has waived his right to testify at the hearing on remand.

Claimant failed to appear at hearing on January 5, 1988. The Referee stated on the record that claimant's counsel had informed her that claimant was aware of the hearing. The Referee issued an Order of Dismissal on January 8, 1988. Claimant moved for abatement of the Order of Dismissal on January 12, 1988. Claimant attached an affidavit in which he swears that he did not receive the notice of hearing and that he has no recollection of being informed of the hearing by his attorney's office. Finally, he swears that had he been aware of the hearing he would have attended. The employer responded to claimant's motion on January 15, 1988. The employer did not attempt to controvert any of claimant's sworn statements in the affidavit.

Accordingly, I conclude that claimant's affidavit establishes, as an uncontroverted fact, that he did not receive the Notice of Hearing and that he was not aware of the hearing. See, Mark S. Lesowske, 41 Van Natta 2154 (November 27, 1989). The majority is apparently unwilling to accept claimant's sworn

statement as a fact. Rather, its opinion attempts to discredit claimant's sworn statement by relying on the fact that the notice was sent to the correct address. The majority has more faith in the postal service than I do. The majority further attempts to discredit claimant's affidavit by noting that claimant admits in his affidavit that his attorney's office stated that it spoke to him about the hearing two weeks before the scheduled hearing. I do not find that admission particularly significant. Claimant swears that he has no recollection of that conversation and that had he been aware of the hearing he would have attended. Those uncontroverted facts establish to my satisfaction that claimant did not have notice or knowledge of the hearing and that if he had notice or knowledge he would have attended.

I would hold that claimant's sworn statement establishes that claimant did not have notice or knowledge of hearing. That fact is sufficient to establish extraordinary circumstances which justify a postponement. Consequently, claimant did not waive his right to testify. I would remand with instructions to allow claimant to testify on his own behalf.

DONNA R. RUEGG, Claimant
Judy Johnson (SAIF), Defense Attorney

WCB 87-18694
December 4, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Zucker's order which: (1) upheld the SAIF Corporation's partial denial of her stomach condition; (2) declined to award temporary total disability; (3) declined to award interim compensation; and (4) declined to assess penalties and associated attorney fees for untimely denial. The issues on review are compensability, temporary total disability, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

SAIF accepted claimant's claim for temporary gastric disorder as nondisabling, and closed it on the same day, November 5, 1987.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Opinion with the following comments.

With respect to the interim compensation issue, ORS 656.262(2) states that compensation is due only upon the employer's/insurer's receiving notice or knowledge of a "claim." Moreover, a claimant is not eligible for interim compensation when, at the time of claim filing, she is off work for a reason unrelated to her injury. Bono v. SAIF, 298 Or 405 (1984). Here, the insurer did not have notice of the claim until long after claimant was discharged from her job for a reason unrelated to her injury. Consequently, the Referee correctly determined that no duty to pay interim compensation arose.

We turn to the issue of a penalty and related attorney fee for untimely denial of claimant's claim. Insofar as the Referee's order could be interpreted as suggesting that a brief delay in accepting or denying a claim cannot support assessment of a penalty, we disagree.

ORS 656.262(10) requires a penalty for "unreasonable" delay. When there is absolutely no reason for delay in payment of compensation, and no reason is evident from the record, the delay, by definition, is unreasonable, no matter how brief. George J. Kovarik, 38 Van Natta 1381 (1986). Here, SAIF received the claim on September 2, 1987. On September 18, SAIF sent a letter to claimant's physician requesting information about the injury. SAIF did not receive a response from the doctor until early November. SAIF accepted the claim on November 5, 1987. We conclude that there was a good reason for the delay; thus, it was not unreasonable. For that reason, a penalty and related attorney fee is not appropriate.

ORDER

The Referee's order dated March 18, 1988 is affirmed.

ROBERTA ZEULNER, Claimant	WCB 87-17817
Black, et al., Claimant's Attorneys	December 4, 1989
Ronald Pomeroy (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Mongrain's order that declined to assess a penalty or associated attorney fee for the SAIF Corporation's alleged failure to comply with a stipulation.

The Board affirms the order of the Referee.

ISSUE

Whether SAIF should be assessed a penalty or associated attorney fee.

FINDINGS OF FACT

Claimant's claim was initially closed by a Determination Order of May, 1984, which awarded 20 percent scheduled permanent disability for a right wrist condition. A second Determination Order issued in March, 1987, stating, inter alia: "The total award to date for the following body part(s) is 37.50 degrees for 25 percent loss of your right forearm." (Emphasis added).

In October, 1987, claimant and SAIF entered into a Stipulation and Order. The order provided, inter alia:

> "The claim was first closed by Determination Order dated May 1, 1984 allowing permanent partial disability of 20 percent. A subsequent Determination Order on March 13, 1987 awarded 25 percent disability.
>
> "* * * * *.
>
> "Claimant shall receive an additional 15

percent scheduled disability for her right arm injury, making the total award to date 60 percent scheduled disability."

Subsequent to the October, 1987, stipulation, SAIF drafted an Amended Stipulation and Order, which included the following language:

> "Claimant is allowed additional scheduled permanent partial disability of 15 percent equal to 22.5 degrees, for a total award of permanent partial disability of 40 percent equal to 60 degrees."

Neither claimant nor her attorney signed the amended stipulation. A letter from SAIF accompanying the amended stipulation explained that the original, October, 1987, stipulation, incorrectly stated that the Determination Order of March, 1987, had awarded 25 percent scheduled permanent disability and that claimant's total award was 60 percent scheduled permanent disability.

ULTIMATE FINDINGS OF FACT

The Stipulation and Order of October, 1987, is ambiguous. The intent of the parties was to award claimant an additional 15 percent scheduled permanent disability, for a total award of 40 percent.

CONCLUSIONS OF LAW

Claimant argues that SAIF should have paid her compensation beyond the "additional 15 percent scheduled permanent disability" awarded by the October, 1987, stipulation. She bases her argument on a miscalculation of her cumulative permanent disability from two prior Determination orders and the 15 percent awarded by the October 1987 stipulation. Claimant's position is without merit.

Given the ambiguity in the stipulation of October, 1987, concerning claimant's total scheduled award, i.e., whether it is 40 or 60 percent, we conclude that extrinsic evidence may be properly relied upon to show the parties' intent. Malor v. Hadley, 86 Or App 687, rev den 304 Or 280 (1987); Oregon Bank v. Nautilus Crane & Equipment Corp., 68 Or App 131 (1984).

SAIF's attempt to correct the October, 1987, stipulation by issuing an amended stipulation with the correct award for the Determination Order of March, 1987, shows that the intention of SAIF was to award an additional 15 percent scheduled permanent disability. Moreover, in July, 1987, a SAIF claim's examiner sent a letter to claimant's attorney "confirming" her offer to settle the matter of claimant's extent of scheduled permanent disability for an additional award of 10 percent. In light of these two extrinsic documents, we find that the intention of the parties was to award claimant an additional award of 15 percent scheduled permanent disability for a total award of 40 percent.

Accordingly, we conclude that SAIF did not unreasonably refuse the payment of compensation by paying claimant an additional 15 percent scheduled permanent disability, pursuant to

the October, 1987, stipulation. See Irene M. Gonzalez, 38 Van Natta 954 (1986). We, therefore, decline to assess either a penalty or an attorney fee.

ORDER

The Referee's order, dated March 8, 1988, is affirmed.

BARBARA KESSLER, Claimant
Thomas O. Carter, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-15465
December 5, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of Referee Tuhy's order which: (1) set aside its denial of claimant's claim for medical services for her current back conditions; and (2) awarded a $1,250 claimant's attorney fee. On review the issues are compensability and attorney fees.

The Board affirms in part, modifies in part and reverses in part.

FINDINGS OF FACT

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

Claimant's sleeping pattern change was first documented on April 30, 1982, which was some 20 months after her compensable low back injury. (Ex. 50-3). Claimant's mid and upper back pain first arose in 1985, around the same time that she had slipped on a riverbank while fishing. (Tr. 36) Prior to seeking medical treatment for her mid and upper back condition, claimant briefly worked as a janitor for another employer performing nonstressful dusting and cleaning activities. It wasn't until May of 1987 that claimant sought medical intervention/chiropractic care for her mid and upper back pain.

FINDING OF ULTIMATE FACT

Claimant's compensable 1980 low back injury did not materially contribute to her mid and upper back condition for which she sought treatment in 1987.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with regard to the reasonable and necessary medical expenses for claimant's continued low back condition. However, we disagree with the Referee's opinion that it is more probable than not from the evidence that claimant's mid and upper back symptoms followed as a natural consequence of the compensable low back injury.

In order to prove the compensability of medical services for her mid and upper back condition, claimant must prove by a preponderance of the evidence, that her 1980 compensable low back injury materially contributed to the existence of her mid and upper back condition. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Senters v. SAIF, 91 Or App 704 (1988). The issue of whether claimant's current mid and upper back condition is causally related to the compensable, 1980, low back injury is a

complex medical question. Although claimant's testimony is probative, the resolution of this question largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Uris v. Compensation Dept., 247 Or 420, 426 (1967).

Claimant testified that her sleeping pattern change subsequent to her continued pain from the compensable injury to her lower back, caused her pain in her mid and upper back. Dr. Woodham, claimant's treating chiropractor, concludes that claimant was never medically stationary from her compensable low back injury and that: "The symptomatology that she [claimant] presented to this clinic with [sic] is a direct manifestation of the kinesiopathic condition that she incurred...[from her compensable 1980 back injury]." (Ex. 70A-3) However, Dr. Woodham does not explain how claimant's mid and upper back condition could be causally related to her compensable low back injury. Furthermore, Dr. Woodham's report contains an inaccurate and incomplete history of claimant's back condition. There is no mention of claimant's changed sleeping pattern and its relationship between the compensable injury and the current condition. There is also no mention of claimant's 1985 fall on the riverbank.

On the other hand, Western Medical Consultants' well reasoned and detailed report indicates no causal relationship between the 1980 compensable low back injury and claimant's upper and mid back condition. We accord the consultants' opinion more weight since its conclusions were both well reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259 (1986).

Therefore, by taking into consideration the five year time gap between claimant's sleep pattern change following her compensable low back injury and her need for medical services for her mid and upper back condition, as well as the persuasive report of the Western Medical Consultants, we conclude that claimant has not proven a material causal connection between the compensable 1980 injury and her current medical services for her mid and upper back condition.

The Referee awarded an assessed fee of $1,250 for setting aside the employer's medical services denial in its entirety. As a result of our above finding that that portion of the denial concerning claimant's mid and upper back is upheld, claimant's attorney fees will be modified. After considering the factors listed in OAR 438-15-010(6), we conclude that $700 is a reasonable award for claimant's attorney for setting aside that portion of the medical services denial which pertained to the low back.

ORDER

The Referee's order, dated May 25, 1988, is affirmed, modified, and reversed. The self insured employer's denial is reinstated and upheld insofar as it pertained to claimant's medical services claim for her mid and upper back condition. In lieu of the Referee's $1,250 attorney fee award, claimant's attorney is awarded a $700 assessed fee for services at the hearing. For services on Board review concerning the low back medical services issue, claimant's attorney is awarded an assessed fee of $300 to be paid by the employer. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $2,158.

DANNIE O. MALAFOURIS, Claimant
Galton, et al., Claimant's Attorneys
Tom Ewing (SAIF), Defense Attorney

WCB 87-18875
December 5, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee McGeorge's order which: (1) allowed the SAIF Corporation to discount medical bills submitted by claimant; (2) found that claimant was not entitled to temporary disability compensation; and (3) declined to assess a penalty and associated attorney fee for alleged unreasonable claims processing. SAIF cross-requests review of that portion of the Referee's order that set aside its denial of claimant's left knee injury claim. On review, the issues are the validity of SAIF's alleged "back-up" denial, discount of medical bills, jurisdiction, and penalties and attorney fees. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's factual findings commencing on page one and continuing through the third full paragraph on page two of her order.

CONCLUSIONS AND OPINION

"Back-up" Denial

Once a claim is accepted under ORS 656.262(6), the employer/insurer may not, after 60 days have elapsed from notice or knowledge of the claim, deny the compensability of that claim unless there is a showing of fraud, misrepresentation or other illegal activity. Bauman v. SAIF, 295 Or 788, 793-94 (1983). Citing Bauman, the Referee determined that SAIF had already accepted claimant's injury claim and, therefore, was precluded from subsequently denying the condition. Moreover, the Referee found no evidence of fraud or misrepresentation which would justify such a retroactive denial. We agree and adopt the Referee's opinion on that issue.

SAIF nevertheless argues that claimant's claim is a "nullity" (and, therefore, that there was no "back-up" denial) because claimant did not file the claim himself, nor did he intend to file a claim. SAIF contends that inherent in the definition of the word "claim" is an intent on the part of the claimant to make a claim. We disagree.

A claim is defined as "a written request for compensation from a subject worker or someone on the worker's behalf . . . ." ORS 656.005(6) (emphasis added). In this case, the hospital filed the claim on claimant's behalf. The statute makes no reference to "intent." Nor has SAIF referred us to any caselaw on this question. We conclude that SAIF's argument is without merit.

Discount of Medical Bills

Claimant argues that SAIF should not be allowed to discount the bills he submitted almost two years after his injury because former OAR 436-10-090(10) applies only to bills submitted by medical service providers, not bills submitted by claimants.

ORS 656.248 gives the Director the authority to

promulgate rules for medical fee schedules. Moreover, disputes regarding the amount of the fee to which a medical service provider is entitled are excluded from the jurisdiction of the Hearings Division. ORS 656.704(3). See Haynes v. Weyerhaeuser Co., 75 Or App 262 (1985). We find that the Referee lacked jurisdiction to address the issue of SAIF's discounting of the billings for claimant's medical services. Accordingly, we vacate that portion of the Referee's order which addressed this issue.

Jurisdiction

Claimant argues that the issue of temporary disability was not before the Referee at hearing and that she should not have made such a determination. We agree.

The Referee's scope of review is limited to issues raised by the parties at hearing. Stephen W. Miles, 41 Van Natta 442 (1989); Allen B. Cooper, 40 Van Natta 1915 (1988). We find that temporary disability was not raised before the Referee at hearing; thus, she lacked jurisdiction to address the issue. Accordingly, we vacate that portion of the Referee's order.

Penalty and Attorney Fee

At hearing, claimant alleged that SAIF's denial of his left knee claim was unreasonable because it was unsupported by any facts supporting a "back-up" denial. On review, claimant does not present any argument regarding the reason SAIF's denial was unreasonable. Given the facts here, we conclude that SAIF's conduct was not unreasonable. The Referee found that SAIF had a legal and factual basis for attempting to establish fraud or misrepresentation regarding claimant's claim. We agree.

In the alternative, for the first time on Board review, claimant argues that SAIF's denial was untimely. Since that issue was not raised at hearing nor considered by the Referee, we decline to consider it. Richard L. White, 41 Van Natta 795 (1989).

ORDER

The Referee's order dated April 25, 1988 is affirmed in part and vacated in part.

CANDICE I. PHILLIPS, Claimant — WCB 87-18818
Quintin B. Estell, Claimant's Attorney — December 5, 1989
Jeff Gerner (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee M. Johnson's order that: (1) awarded an additional 5 percent (16 degrees) unscheduled permanent disability for her low back condition, beyond a Determination Order that awarded 10 percent (32 degrees); and (2) declined to award scheduled permanent disability for her left leg condition.

The Board affirms in part and reverses in part the order of the Referee.

ISSUES

1. The extent of claimant's unscheduled permanent disability for her low back condition.

2. The extent of claimant's scheduled permanent disability for her left leg condition.

FINDINGS OF FACT

The Board adopts the Referee's "Facts", both uncontroverted and found, and makes the following additional findings.

Claimant experiences frequent radiating pain into her left lower extremity. That pain impairs her ability to walk and climb.

CONCLUSIONS OF LAW

Unscheduled Disability

The test for determining the extent of unscheduled permanent disability is "loss of earning capacity." ORS 656.214(5).

Although we agree with the Referee's award of unscheduled permanent disability, we disagree with his consideration of her scheduled disability in arriving at that award.

Claimant has a compensable herniated nucleus pulposus at L5-S1, resulting in "mild" permanent physical impairment. She is only 29 years of age, however, and has obtained certification as an Emergency Medical Technician-4. In addition, she has a broad range of work experience within the health care field.

Considering claimant's level of permanent physical impairment, her relative youth, her prior work experience, and her transferable skills within the health care field, we conclude that the Referee's additional award of 5 percent unscheduled permanent disability, for a total award of 15 percent, adequately compensates claimant for her permanent loss of earning capacity due to her compensable injury.

Scheduled Disability

Finding that claimant's left leg disability "emanates from her low back injury[,]" the Referee declined to award scheduled permanent disability. Although we have no quarrel with the Referee's finding, we disagree with his failure to award scheduled permanent disability.

As the Referee correctly noted in his order; a separate but additional award should be made for loss of function of a scheduled body part, even though the scheduled impairment is traceable to an injury to an unscheduled portion of the body. Victoria W. Fox, 37 Van Natta 10, 11 (1985); see also Foster v. SAIF, 259 Or 86, 91 (1971); Olds v. Superior Fast Freight, 36 Or App 673 (1978).

Here, claimant experiences frequent pain in her left lower extremity. As a result, her ability to walk and climb are impaired. In the light of that impairment, which we view as minimal, we conclude that her left leg pain is disabling.

Accordingly, an award of 5 percent scheduled permanent

disability adequately compensates claimant for her permanent loss of use or function in her left leg.

ORDER

The Referee's order, dated May 5, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that declined to award scheduled permanent disability is reversed. Claimant is awarded 5 percent (7.5 degrees) for her scheduled loss of use or function in her left leg. All remaining portions of the Referee's order are affirmed.

Claimant's attorney is awarded an approved fee, payable out of claimant's compensation, equal to 25 percent of the increased compensation awarded by this order, provided that the total of fees approved by the Referee and the Board do not exceed $3,800.

ROY E. SPEIGHT, Claimant
Patrick K. Mackin, Claimant's Attorney
Roy Miller (SAIF), Defense Attorney
Jacqueline A. Weber, Defense Attorney

WCB 89-06178 & 88-17191
December 5, 1989
Order Denying Motion to Dismiss

Claimant has moved for an order dismissing Safeco Insurance's request for review of a Referee's order on the grounds that Safeco did not request review. The motion is denied.

FINDINGS

The Referee's order issued October 10, 1989. On October 26, 1989, the Board's Portland office received a "Request for Review" from Safeco. The request stated as follows:

> "Respondent Safeco Insurance Company respectfully requests that the Workers' Compensation Board review the referee's Opinion and Order made and entered on October 10, 1989, less than 30 days before the date of this Request for Review."

A cover letter accompanying the request was addressed to the Referee at the Hearings Division for the Board at its Portland office. The request included a certificate of personal service by mail upon the other parties to the proceeding and their respective counsels.

On November 2, 1989, the Board mailed a computer-generated letter to the parties acknowledging a request for review.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). 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).

The request for review by the Board of a Referee's order need only state that the party requests a review of the order.

ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to properly identify a document as a party's request for Board review of a Referee's order. Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

Claimant contends that Safeco's request should be dismissed because the request was mailed to the Referee, not the Board. In support of his contention, claimant relies upon Myron A. Schmidt, 41 Van Natta 896 (1989), and June M. Hejduk, 41 Van Natta 887 (1989), where we concluded that the Board lacked jurisdiction to consider alleged requests for review which had been directed to the Referee who had issued the order. We consider this case to be distinguishable from the aforementioned decisions.

As in Schmidt and Hejduk, the present request was directed to the Referee. However, in each of those cases, the requesting party was asking the Referee to take further action. i.e., set aside or vacate the prior order. Since the intention of the requesting party was both clear and unmistakable, we held that Board review had not been sought.

Here, in contrast to the Schmidt and Hejduk decisions, Safeco did not request the Referee to take any action. Although the cover letter which accompanied its request was addressed to the Referee, the request itself was expressly titled "Request for Review" and specifically stated that Safeco was requesting Board review of the Referee's October 10, 1989 order.

Under such circumstances, we conclude that the intention expressed in Safeco's request is both clear and unmistakable. i.e., it was requesting Board review of the Referee's order. Inasmuch as Safeco's request was received by a permanently staffed office of the Board and copies were also mailed to the remaining parties within 30 days of the Referee's October 10, 1989 order, we conclude that we have jurisdiction to consider this case. ORS 656.289(3); 656.295(1), (2); OAR 438-05-046(1)(a).

Accordingly, the motion to dismiss is denied. Upon receipt of the hearing transcript, copies will be distributed to the parties and a briefing schedule will be implemented. Thereafter, the case will be docketed for review.

IT IS SO ORDERED.

GEORGE VAN DAM, Claimant	WCB 86-11743
Donald L. Dickerson, Claimant's Attorney	December 5, 1989
SAIF Corp Legal, Defense Attorney	Order on Review

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Heid's order that set aside its denial of claimant's occupational disease claim for a knee and leg condition. On review, the sole issue is compensability.

We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate fact.

CONCLUSIONS OF LAW AND OPINION

To prevail on his occupational disease claim, claimant must demonstrate that his work activities, when compared to nonwork activities, were the major contributing cause of the onset of his knee and leg condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985).

In finding the claim compensable, the Referee relied on a temporal relationship between the onset of claimant's condition and his work activity, and the absence of evidence indicating that off-work activities contributed to the condition. He concluded that this evidence was sufficient to establish compensability under the Court of Appeals decision in Ford v. SAIF, 71 Or App 825 (1985). On review, SAIF contends that claimant has not carried his burden of proving compensability. We agree.

We do not dispute the Referee's finding that claimant is a credible witness, and we recognize that his lay testimony is probative. However, the medical evidence is contrary to claimant's position. Absent a persuasive medical opinion supporting compensability, a temporal relationship between claimant's symptoms and work activities is not sufficient to satisfy his burden of proof. See Allie v. SAIF, 79 Or App 284, 287 (1986); John B. Guerrero, 40 Van Natta 922 (1988).

This case is distinguishable from Ford v. SAIF, supra., the decision relied on by the Referee. In Ford, the court found claimant's hearing loss compensable based, in part, on the existence of a temporal relationship between the hearing loss and claimant's work activity. However, the medical evidence in that case either supported compensability or was neutral on the causation issue. In particular, the medical evidence established that claimant's hearing loss was due to noise exposure, and medical opinions from two consulting hearing specialists indicated that claimant's work activity was the primary source of noise exposure. Here, all medical opinion is contrary to claimant's position. Accord Bradshaw v. SAIF, 69 Or App 587 (1984) (temporal relationship sufficient where medical opinion supports compensability).

Accordingly, we conclude that claimant has not carried his burden of proving compensability, and we reverse the Referee's decision.

ORDER

The Referee's order, dated February 3, 1988, is reversed. The SAIF Corporation's denial is reinstated and upheld.

LELAND CHASE, Claimant
Stebbins & Coffey, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 87-06198
December 6, 1989
Order on Review

Reviewed by Board Members Brittingham and Crider.

The self-insured employer requests review of Referee Blevins' order which granted claimant permanent total disability, whereas prior Determination Orders had awarded a total of 45 percent (144 degrees) unscheduled permanent disability for a neck and shoulder injury. The issue is extent of permanent disability, including claimant's entitlement to permanent total disability. We affirm.

FINDINGS OF FACT

Claimant was 60 years of age at hearing. He is a former service manager for a Coos Bay automotive center. He was employed as the service manager for 12 years, beginning in February 1973. From 1963 to 1973, he was self-employed as a service station owner/manager and worked as a service station mechanic for 15 years prior to that. He served in the Navy from 1944 to 1948. He is a high school graduate.

On January 4, 1985, claimant injured his neck and left shoulder at work while pulling a tire down from an overhead rack. Claimant evidenced cervical nerve root impingement, and on January 25, 1985, Dr. Golden, M.D., performed a cervical laminectomy at C6-7.

Claimant's condition improved following the surgery; however, he continued to experience some intermittent neck pain near the surgical site. In May 1985, claimant enrolled in the Callahan Center for vocational evaluation and work hardening. At that time, he was capable of returning to work in the light-medium range. During the May 1985 evaluation, claimant exhibited excellent reading and arithmetic skills. He was found to have a large variety of aptitudes and transferable skills.

Claimant wanted to return to work for the at-injury employer. However, subsequent to his January 1985 injury, the service center closed. Claimant worked with his vocational counselor to locate employment at one of the employer's other automotive service center locations. However, no positions were offered to claimant.

A Determination Order issued on October 4, 1985, awarding claimant 15 percent unscheduled permanent partial disability. Claimant began treating with Dr. Bert, orthopedist, in November 1985. In May 1986, the claim was reopened.

The Orthopaedic Consultants examined claimant on January 20, 1987. The panel diagnosed: (1) status post diskectomy and foraminotomy at C6-7, with residuals; (2) spondylosis, cervical spine; (3) adhesive capsulitis, both shoulders, relation to industrial injury unclear; (4) possible early Parkinson's disease, unrelated to industrial injury; (5) glaucoma, unrelated to injury; and (6) prostatism, unrelated to industrial injury. Dr. Tearse, neurologist, conducted an independent medical examination on March 16, 1987.

A second Determination Order issued April 13, 1987,

awarding claimant an additional 30 percent unscheduled permanent disability for a total of 45 percent unscheduled disability. On July 21, 1987, claimant was awarded Social Security disability benefits, effective October 14, 1986.

Claimant requested a hearing on the April 1987 Determination Order. At the time of hearing, claimant was able to care for himself. He was able to drive, and he walked up to two miles each day for exercise. He was able to grocery shop and carry grocery bags from the store to his car.

Claimant cooperated with vocational efforts made on his behalf in attempting to regain employment with the employer in another city. However, claimant's active seek work efforts ended in November 1985, when his treating doctor, Dr. Bert, M.D., restricted him from conducting additional job search activities. Although claimant did not actively search for work after November 1985, he continued to cooperate with his vocational counselor until she determined vocational services would not aid claimant's reemployment given his age, physical limitations and other pertinent social and educational factors.

FINDINGS OF ULTIMATE FACT

Claimant possesses skills and aptitudes transferable to a large number of light duty and medium duty jobs. However, he is physically disabled from performing any work other than of a sedentary nature, with lift and carry limitations not to exceed 10 pounds, and restrictions on overhead reaching and bending of the upper torso. Claimant has no transferable skills that would enable him to perform sedentary work. Claimant's age makes it impractical to retrain him for sedentary work that will permit him to effectively sell his services in the market place. Claimant has cooperated with vocational efforts made on his behalf. Prior to the worsening of his condition and the reopening of his claim in 1986, he exhibited a willingness to seek employment within his limitations. In any event, considering claimant's permanent impairment and relevant social/vocational factors, it is futile for him to seek work.

CONCLUSIONS AND OPINION

The Referee determined claimant was physically limited to performing sedentary work and on that basis found claimant permanently and totally disabled as of March 16, 1987. We agree.

ORS 656.206 (1)(a) defines permanent total disability as the: "loss ... of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation."

Claimant is not totally physically incapacitated. Dr. Bert, claimant's treating orthopedist, has indicated that claimant may return to sedentary work with lifting and carrying restrictions of no more than 10 pounds. The Orthopaedic Consultants stated that claimant could return to work at a job that was "completely sedentary." Dr. Tearse placed lifting restrictions of five to ten pounds should claimant return to work. Claimant is able to care for himself. He is able to drive and walks up to two miles per day for exercise. He is able to grocery shop and carry grocery bags from the store to his car.

Although claimant is not totally physically incapacitated, he can still establish entitlement to a permanent total disability award under the so-called "odd lot" doctrine. Under that doctrine, claimant may establish permanent total disability due to a combination of his physical condition and certain nonmedical factors, such as age, education, and work experience. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). If claimant relies on the "odd lot" doctrine, he is required to make reasonable efforts to find work, unless job seeking activities would be futile. ORS 656.206(3); Welch v. Bannister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

Vocational studies indicate that claimant has a number of transferable skills that could be marketable if he was capable of light duty or heavier employment. Of over 4000 jobs initially searched, claimant's vocational counselor, Ms. Wicks, narrowed her search down to 12 jobs which may have been suitable for claimant given his skills and physical limitations. Yet, upon further review, she found none of the 12 jobs were appropriate for claimant. Vocational expert, Mr. Dibble, testifying at claimant's Social Security Disability hearing, identified five jobs claimant had the necessary skills to perform if he had been released to light duty work. However, all of these possibilities were eliminated when claimant was restricted to sedentary work. Considering claimant's restriction to sedentary employment, vocational consultant, Mr. McNaught, opined claimant was unemployable. Finally, the judge at claimant's Social Security hearing in 1987 found claimant unemployable as of October 14, 1986.

Based on this evidence, we conclude that claimant's advanced age and lack of skills transferable to sedentary-type work do not permit him to effectively sell his services in the job market. We agree with vocational expert, Mr. McNaught, that if claimant were 20 years younger, he would be an excellent candidate for retraining. However, we place great weight on the adverse effect claimant's age would have on his employability and conclude that retraining at this date is not realistic and would not make his services any more marketable than they are at present. In any event, claimant must be rated as of the date of hearing, not as of some future date following retraining. Gettman v. SAIF, 289 Or 609 (1980).

Along this same line of reasoning, we find claimant has made a reasonable effort to find employment. Claimant has at all times cooperated with vocational efforts made on his behalf. The employer accurately notes that claimant has not actively looked for work since 1985. However, claimant's physician, Dr. Bert, restricted claimant from work search activities after the claim was reopened in November 1985. Although claimant has done nothing in terms of work search since the claim was closed in April 1987, we find that he is excused from this requirement because of the futility of the search. Nonmedical factors, such as age and transferable skills, which establish permanent total disability under the "odd lot doctrine" may, as in this case, make seek-work efforts futile. SAIF v. Simpson, 88 Or App 638 (1987); See also Georgia Pacific Corp. v. Perry, 92 Or App 56 (1988). Considering claimant's physical restrictions, advanced age and limited transferable skills, we conclude that it would be futile for him to seek further employment.

The employer contends that the Referee erred in determining that claimant is limited to sedentary work and that, in fact, claimant is capable of light duty work. Obviously, if this were the case, claimant would have a number of job opportunities for which he has transferable skills. However, we agree with the Referee that, based on claimant's lift and carry restrictions along with restrictions on claimant's ability to reach and bend, his physical capacity is properly in the sedentary category.

Accordingly, we agree with the Referee that claimant has established his entitlement to permanent total disability. Claimant's physical limitations combined with the "odd lot" factors of age, education and training establish claimant's permanent and total disability. See Lee v. Freightliner Corp., 77 Or App 238 (1984).

Claimant's counsel is statutorily entitled to a reasonable carrier-paid fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order, dated November 17, 1987, is affirmed. A client-paid fee, not to exceed $622.50, is approved.

LENA M. FISHER, Claimant
Richard A. Sly, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney

WCB 87-14046
December 6, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Higashi's order that upheld the SAIF Corporation's denial of her claim for a heart condition and job-related stress. SAIF requests review of the Referee's admission of evidence not timely submitted prior to hearing. On review, the issues are evidence and compensability.

We reverse on the compensability issue.

FINDINGS OF FACT

Claimant began working at the employer's family-operated ambulance service as a payroll and bookkeeping clerk in January 1980. She began experiencing episodes of left arm and chest discomfort in 1982. These symptoms were associated with periods of unusual stress at work. She had no prior history of arm, chest or heart problems.

Sometime around 1984, the son of the owner began taking an increasing role in the management of the business, and the son's wife became claimant's immediate supervisor. The son instituted a standardized pay scale under which claimant received pay raises that were lower than those of other employees, and lower than the increases she had received in the past. As a result, claimant felt that she was being treated unfairly. The son also instituted new payroll accounting policies, whereas claimant had previously been entirely responsible for the payroll

process. Claimant felt that the new policy was instituted because the owner and his son no longer trusted her. Her feelings were reinforced when the owner left an article about employee embezzlement on her desk, and the son made comments regarding claimant's opportunity to embezzle company funds.

Claimant was further troubled by her suspicion that the son was eavesdropping on her telephone conversations. The employer was required by law to record all incoming phone calls. Claimant believed the son was monitoring recordings of her calls because he had knowledge of specific telephone conversations and, on occasion, requested that she reduce her personal use of the phone.

Claimant was also disturbed by other events at work. She received conflicting instructions from the owner, his son and the son's wife; and they engaged in heated arguments in her presence. The son confronted claimant about her telephone conversations with his ex-wife, and he became angry when his mother presented claimant with a Christmas present. Claimant was informed of a potential garnishment order on the son's salary, and she was concerned over her role in enforcing that order. On one occasion, the son's wife severely criticized claimant about a billing problem for which she was not responsible. The owner and his son also asked claimant to cover the phones during lunch, and when she refused they continued to request that she perform this function. Finally, the son acted in a teasing and joking manner when she talked with him about her grievances, and he instructed her not to talk with other employees about work problems.

As a result of these changes in claimant's work environment, she was under increasing amounts of stress at work. In late 1985, she began experiencing more frequent episodes of left arm and chest pain, along with heart palpitations. She threatened to quit in November 1986, but the owner and his son persuaded her to stay. By May 1987, she was also experiencing episodes of tearfulness, anxiety, disturbed sleep and depression.

Claimant first sought treatment for her symptoms in late 1985. Diagnostic studies performed in January 1986 identified an abnormal, congenital heart condition, described as a mitral valve prolapse. Her family physician, Dr. Booth, M.D., attributed claimant's symptoms to "job stress reaction" and an exacerbation of her mitral valve prolapse condition. Dr. Booth prescribed Inderal for claimant's left arm and chest pain, and Librium for her emotional problems. Dr. Booth also recommended that claimant quit her job for health reasons. The owner's son encouraged claimant not to quit, but she left her job in late May 1987.

Claimant's condition markedly improved over the next two months. Dr. Turco, psychiatrist, performed an independent medical examination in mid-July 1987. He noted no symptoms of stress, anxiety or depression. In August 1987, Dr. Kremkau, cardiologist, performed an independent medical examination and file review. She found no evidence that claimant's mitral valve prolapse was symptomatic and attributed claimant's physical symptoms to stress-induced musculoskeletal discomfort.

Claimant was exposed to potentially stressful events in her personal life in 1986 and 1987. Her mother was diagnosed with cancer in December 1986, and claimant drove her to and from her cancer treatments. In addition, claimant's husband used a

substantial portion of their savings to go into business for himself in March 1987.

Claimant's employer was insured by SAIF. In May 1987, claimant filed a claim for mitral valve prolapse and job stress reaction, SAIF issued a denial, and claimant requested a hearing. Claimant testified in a credible and reliable manner. At the time of hearing, she had been virtually asymptomatic since June 1987. However, she had not returned to work.

SAIF provided claimant a copy of its hearing exhibits on November 25, 1987. Based on a review of these exhibits, claimant's attorney determined that an additional opinion from a cardiologist was necessary regarding the relationship between claimant's work stress and mitral valve prolapse condition. On December 4, 1987, claimant requested a postponement to obtain that opinion, and the request was denied on or around December 8, 1987. In the interim, claimant's attorney solicited no further reports in reliance on the possibility of a postponement. When the postponement was denied, claimant's attorney solicited a follow-up report from treating physician Booth on December 9, 1987. The following day, Dr. Booth completed a report in which she restated her previous opinion in a clearer and more detailed fashion. Claimant's attorney received Dr. Booth's report on December 11, 1987 and submitted it to the Referee on the same day.

The hearing was held on December 16, 1987. The Referee admitted Dr. Booth's December 11, 1987 report over SAIF's objection. The Referee offered SAIF the opportunity to cross-examine Dr. Booth, and SAIF expressed its intention to have its own medical expert critique Dr. Booth's report. However, SAIF apparently did not avail itself of these opportunities.

FINDINGS OF ULTIMATE FACT

Claimant's left arm and chest discomfort and heart palpitations were attributable to stress-induced musculoskeletal discomfort. They were not related to her congenital mitral valve prolapse condition.

Claimant's stress reaction was triggered by real work events which objectively could cause stress.

Although events in claimant's personal life were potentially stressful, there is no persuasive evidence that these events significantly contributed to her stress reaction.

Claimant's work stress was the major contributing cause of her physical and emotional stress reaction.

Claimant's job stress reaction was disabling and required medical treatment.

CONCLUSIONS OF LAW AND OPINION

Admissibility of Evidence

SAIF contends that the Referee erred in admitting Dr. Booth's December 10, 1987 report. We disagree.

The applicable administrative rules governing

admission of evidence at the December 1987 hearing are set forth in former OAR 438-07-005(3)(b) and (4). Under these rules in effect at the time of this hearing, Dr. Booth's report was admissible at the Referee's discretion on a showing of good cause for untimely submission.

We conclude that the Referee did not abuse his discretion in admitting Dr. Booth's report. The Referee made the requisite finding of good cause before admitting the report into evidence. Specifically, he concluded that claimant had acted reasonably in not soliciting the report until his request for postponement was denied. The Referee also correctly noted that "the interests of justice and the search for truth" were served by admission of the report. Moreover, Dr. Booth did not render a new opinion in the report, but merely restated her previous opinion in a clearer and more detailed fashion. Finally, the Referee offered SAIF the opportunity to respond to the report. Under these circumstances, the Referee did not abuse his discretion in admitting Dr. Booth's report.

Compensability

Claimant contends that the Referee erred in concluding that her mitral valve prolapse and stress conditions are not compensable. Although we disagree with the Referee's analysis regarding claimant's mitral valve prolapse, we agree with his ultimate conclusion that this condition is not compensable. However, we are persuaded that claimant's stress condition is compensable, and we reverse the Referee on this issue.

Mitral Valve Prolapse

The Referee attributed claimant's left arm and chest pain and heart palpitations to her congenital mitral valve prolapse. He further concluded that these symptoms were not compensable because claimant had not demonstrated a worsening of her congenital condition, as distinct from a mere symptomatic flare-up.

The Referee apparently relied on Dr. Booth's opinion that claimant's physical symptoms were related to her mitral valve prolapse condition. We are not persuaded by Dr. Booth's opinion and rely, instead, on the opinion of Dr. Kremkau, cardiologist. She found no evidence that claimant's mitral valve prolapse was symptomatic and, instead, attributed claimant's symptoms to stress-induced musculoskeletal discomfort. Dr. Kremkau's opinion is entitled to greater weight because she is a specialist in heart diseases, whereas Dr. Booth has no special training in this area.

We, therefore, defer to Dr. Kremkau's opinion and conclude that claimant's symptoms were not related to her mitral valve prolapse condition. For this reason only, we affirm the Referee's ultimate conclusion that claimant's mitral valve prolapse condition is not compensable.

Job-Stress Reaction

In order to establish a compensable stress condition, claimant must first demonstrate that real on-the-job events, objectively capable of producing stress, were the major contributing cause of her stress reaction. See McGarrah v. SAIF, 296 Or 145, 165-166 (1983); Peterson v. SAIF, 78 Or 167, 170

(1986). Claimant must, then, prove that her stress reaction required treatment or resulted in disability. ORS 656.804 and former ORS 656.005(8)(a).

As we read the Referee's order, he concluded that claimant had satisfied the first portion of her burden of proof. We agree. Claimant experienced stress as a result of her feelings that she was being treated unfairly and was no longer trusted and appreciated. The record indicates that claimant's perceptions were based on numerous "real events" which were objectively capable of causing stress, including: receiving lower salary increases under the new pay scale; increased supervision of her payroll and bookkeeping activities; having articles on employee embezzlement left on her desk by the owner; comments from the owner's son regarding her opportunity to embezzle company funds; the employer's recording of her phone calls and knowledge of specific phone conversations; receiving conflicting instructions from the owner and his family; and being caught in the middle of their personal quarrels.

We further conclude that these stressful work events were the major contributing cause of claimant's stress reaction. This conclusion is consistent with the opinions of treating physician Booth and cardiologist Kremkau. It is further supported by the absence of persuasive evidence that claimant's personal life significantly contributed to her stress.

We turn to the second portion of claimant's burden of proof. The Referee concluded that her stress condition was not compensable because it did not cause a psychiatric condition requiring treatment. We disagree. Claimant's psychiatric symptoms were serious enough in May 1987 to prompt Dr. Booth to prescribe Librium. We are aware that Dr. Turco opined that claimant was not suffering from a disabling or treatable psychological condition. However, we discount his opinion because it was based on his examination of claimant in July 1987, after her psychological symptoms had essentially resolved.

In addition, the Referee erred in limiting his inquiry to whether claimant's condition required treatment. He should also have determined whether it resulted in disability. See former ORS 656.005(8)(a). Furthermore, the Referee only considered claimant's psychiatric condition. As discussed above, he should have considered claimant's entire symptom complex, physical and mental, in determining whether her stress reaction required treatment or resulted in disability.

Dr. Booth took claimant off work because of her mental and physical symptoms, and Drs. Booth and Kremkau both opined that claimant should not return to work for the employer because of her stress condition. In light of these factors, we conclude that claimant has demonstrated that her stress reaction required treatment and resulted in disability.

Accordingly, claimant has established a compensable stress condition, and we reverse the Referee on this issue.

ORDER

The Referee's order, dated December 31, 1987, is affirmed in part and reversed in part. That part of the order that upheld the SAIF Corporation's denial of claimant's job stress

reaction is reversed. The claim is remanded to SAIF for further processing. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $1500 for services at hearing, and $1200 for services on review, to be paid by SAIF.

STEVEN R. KRUESI, Claimant
Emmons, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-14344
December 6, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Mirassou's order that upheld the insurer's partial denial of claimant's varicose veins condition. On review, the issue is compensability. We reverse.

FINDINGS

On February 23, 1986, claimant, while employed by a plywood mill, injured his left knee when he fell upon the iron edge of a drying cart. In the next few days, there was swelling, and a two to three inch oblong contusion arose across the kneecap. One week later, a lump about the size of a large marble manifested itself along the top edge of the contusion. Thereafter, more lumps formed going across the kneecap, and down toward the calf. Claimant also experienced pain, and was unable to kneel or bend the knee. Claimant reported the knee injury to his employer, but missed no time from work because of it.

Prior to the injury, claimant had experienced no symptoms related to his knee or varicose veins. However, he did have a preexisting condition of varicose veins. His mother also had a medical history of the same condition.

On March 13, 1986, claimant sought treatment for his knee from family practitioner, Dr. Origer. At the site of the contusion, a cluster of varicose veins was noted. Claimant was diagnosed with "knee contusion which worsened preexisting varicose veins." It was recommended that claimant undergo vein stripping and ligation to relieve symptoms. Claimant submitted a claim for an injured knee on March 13, 1986, which was accepted as a nondisabling knee contusion by the insurer on April 25, 1986.

On July 31, 1986, claimant underwent surgery by Dr. Brossart, a vascular surgeon. Claimant chose to have the surgery done at this time, because he was on time loss for a prior compensable back injury. Claimant's pain, discoloration, and lumps went away shortly after the surgery. On August 18, 1986, claimant was declared medically stationary by Dr. Brossart.

On October 7, 1986, the insurer acknowledged acceptance of claimant's left knee injury, but denied the preexisting varicose veins condition and subsequent surgery claim, on the grounds the varicose veins condition was unrelated to the knee injury. The insurer further asserted that claimant did not obtain pre-authorization for elective surgery as required under the administrative rules.

ULTIMATE FINDINGS OF FACT

The February 23, 1986 compensable left knee injury

materially contributed to a symptomatic worsening of claimant's preexisting varicose veins condition to the extent surgery was required.

CONCLUSIONS OF LAW

The Referee concluded that claimant's varicose veins condition was not compensable. In so holding, she weighed the differing opinions of the medical doctors, and found Drs. Porter and Dennis to be more persuasive than Drs. Origer and Brossart. The opinion of Dr. Gripekoven she discounted. Since neither Dr. Porter nor Dr. Dennis opined that there was a causal connection between the knee injury and the preexisting varicose veins condition, the Referee concluded there was no worsening caused by the knee injury. Inasmuch as we do not find the opinions of Drs. Porter and Dennis to be persuasive, we reverse the Referee's decision.

In order to establish compensability of the varicose veins condition, claimant need not prove that the injury caused a worsening of the preexisting condition. Rather, claimant need only show that the compensable left knee injury caused the varicose veins to become symptomatic. Grace v. SAIF, 76 Or App 511 (1985); Jameson v. SAIF, 63 Or App 553, 555 (1983); Brian C. Roll, 40 Van Natta 2046 (1988).

However, claimant must show the compensable injury was a material contributing cause of the need for reasonable and necessary medical services. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987). Material contributing cause means a substantial cause, but not necessarily the sole cause or even the most significant cause. Van Blokland, supra, 87 Or App at 698.

The causation of claimant's condition presents a complex medical question. Hence, although claimant's credible testimony is probative, resolution of the case turns on the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant's compensable injury was the traumatic injury to the left kneecap area which overlaid a cluster of preexisting varicose veins. As a result of the injury, these varicose veins flared up and required treatment. Therefore, the compensable knee injury was a significant cause of the need for surgery of the varicose veins, and that treatment was compensable.

Thus, we conclude that claimant's current disability was brought on by his compensable knee injury. Although the injury may not have worsened the underlying varicose veins, it did precipitate the symptoms which ultimately led to surgery.

In reaching our conclusion we give great weight to the medical opinions of claimant's treating doctor and surgeon, Drs. Brossart and Origer. Both saw and treated claimant shortly after his compensable injury. Each attributed the causation for claimant's current condition, and ultimate surgical solution, to the February 23, 1986 compensable injury.

We conclude that the medical opinions of Drs. Brossart and Origer establish claimant's varicose veins condition as compensable, even though there is medical opinion in the record concluding that his condition and surgery was not work related.

In particular, we rely upon the medical opinion of vascular surgeon, Dr. Brossart. He has consistently attributed causation to the February 23, 1986 compensable injury. Dr. Brossart's conclusions were based not only upon symptoms immediately presenting themselves after the knee injury occurred, but also because he believed trauma can cause, and in claimant's case did cause, worsening of the preexisting condition. Although Dr. Brossart noted the causal role frequently played by other factors, he did not opine that other factors were responsible in claimant's case.

As claimant's treating surgeon, Dr. Brossart was able to observe claimant's knee during surgery. Significantly, he saw no evidence that the varicose veins were the result of any other factor. Because of his first-hand exposure to and knowledge of claimant's condition, we give his opinion great weight. Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988).

Dr. Brossart's opinion is supported by that of the treating physician, Dr. Origer. Within three weeks of the injury, claimant reported to Dr. Origer with complaints of mild achiness and soft, spongy swelling beside the kneecap at the site of injury. Dr. Origer noted a cluster of varicose veins lateral to the inferior pole of the patella, which claimant also indicated as the site of injury. Dr. Origer concluded that the knee contusion worsened the preexisting varicose veins, and recommended eventual vein stripping and ligation. Dr. Origer squarely related causation to the injury. He stated: "the contusion occurred on top of a preexisting varicose vein and caused aggravation and worsening of the preexisting varicose vein."

We are not persuaded by the contrary opinions of Drs. Gripekoven, Porter, and Dennis. The Referee appropriately disregarded Dr. Gripekoven's opinion. Not only was this opinion prepared solely in response to claims processing issues, it did not directly address the question of the causation of claimant's condition. Rather, Dr. Gripekoven's opinion merely reflected his skepticism of the probabilities of a contusion causing or worsening a varicose veins condition sufficient to require surgery.

Dr. Porter's opinion is not persuasive either. His opinion is based upon a review of the medical record, and not on a personal examination of claimant. He also expresses doubt, in the abstract, about the probabilities of a contusion causing a worsening of a varicose veins condition, and concludes that claimant's injury did not cause the current varicose veins condition.

Further, despite his impressive credentials as Division Head of Vascular Surgery at Oregon Health Science University, Dr. Porter's opinion is given little weight as it is based on the following faulty premises: (1) he believed that claimant suffered from a "relatively minor contusion;" (2) he was unaware of any specific symptoms referrable to the varicose veins experienced by claimant; and (3) he believed that claimant's decision to have the varicose veins removed was an "elective decision of convenience rather then being precipitated by any symptoms."

These premises are incorrect. The record indicates that claimant's injury was more then a mere bruise. From the outset,

claimant experienced symptoms directly related to the varicose veins that were both immediate and continuing. Both claimant and his wife credibly testified to the presence of lumps, pain, and reduced ability to kneel and bend. As a result, both his treating physician and treating surgeon recommended surgery for the relief of symptoms. Although the timing of the surgery may have been elective, the need was not.

On June 16, 1987, claimant was examined by Dr. Dennis, a vascular surgeon. Dr. Dennis also found it unlikely that the injury could have produced causation or worsening of the varicose veins condition. His ultimate conclusion was that the injury, and the varicose veins condition, were "coincidental," and that the injury only served to draw claimant's attention to the presence of varicosities. No further explanation is provided by Dr. Dennis. We reject this opinion as superficial and conclusory, and give Dr. Dennis' opinion little weight.

Accordingly, we find that claimant has proven by a preponderance of the evidence that his February 23, 1986 compensable left knee injury caused his previous asymptomatic preexisting varicose veins condition to become symptomatic and necessitated the subsequent surgery. That is sufficient to make his current condition compensable. Grace, supra, at 517.

ORDER

The Referee's order, dated December 1, 1987, is reversed in part. The insurer's denial is set aside, and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on Board review, claimant's counsel is awarded a reasonable assessed fee of $1,520, to be paid by the insurer. A client-paid fee not to exceed $1,075.50 is approved.

ALICE V. MALONEY, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 87-04713
December 6, 1989
Order on Review

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of that portion of Referee Higashi's order that granted claimant permanent total disability, in lieu of Determination Orders that awarded 40 percent (128 degrees) unscheduled permanent disability for a low back injury. On review, the issue is permanent total disability.

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

In order to prove permanent total disability, claimant must prove either that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social/vocational factors, effectively prohibit her further employment under the "odd-lot" doctrine. See Wilson v. Weyerhaeuser, 30 Or App 403 (1977). The Referee found that claimant was completely physically disabled and therefore precluded from gainful employment. The medical evidence supports that conclusion and we affirm.

In addition, we would also find claimant to be permanently and totally disabled under the "odd lot" doctrine.

Wilson v. Weyerhaeuser, supra. In Wilson, the court described the factors generally considered in determining permanent total disability in "odd lot" cases. Those factors include: age, training, aptitude, adaptability, mental capacity, and emotional condition.

Claimant was 61 years of age at hearing. She sustained a prior compensable injury in 1982 and still suffered residual pain from that injury when she received the current compensable injury in 1985. Prior to her 1985 compensable low back injury, she was on a reduced work schedule and was having difficulty performing her job. Since this injury, she has chronic pain syndrome involving the back, shoulders, and hip. As a result of her 1985 compensable injury, she has developed mental problems involving depression, forgetfulness, inability to concentrate, and loss of sensory perception.

In addition, claimant was not physically or psychologically able to complete vocational rehabilitation. Her treating physician opined that she is not capable of returning to her prior employment or to any employment. A vocational rehabilitation counselor testified that it would not be possible to describe a suitable occupation for claimant.

The Referee found that a combination of both medical and psychological factors contributed to claimant's incapacitation sufficiently to support a finding of permanent and total disability. We agree.

In reaching this conclusion, we note that claimant's preexisting diabetes is occasionally out of control, exacerbating her mental and physical problems and causing her to become dizzy. Yet, claimant's diabetes was present at the time of the compensable injury and not disabling, nor has it been worsened by the compensable injury. Therefore, we have not considered the diabetes in rating permanent total disability. Donald L. Savage, 39 Van Natta 758, 760 (1987).

Our review is to determine if there is a realistic likelihood that claimant could perform services for which there exists a reasonably stable market. See Max S. Swanberg, 39 Van Natta 823 (1987); compare, Loretta Amstad, 40 Van Natta 1001 (1988). After considering claimant's compensable 1985 low back injury and its residuals, as well as the relevant social/vocational factors, we find that claimant is not capable of being gainfully employed. We also find that, as a result of her 1985 compensable injury, it is futile for claimant to seek work or participate in vocational rehabilitation. Accordingly, we find that she is permanently and totally disabled.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated November 23, 1987, is affirmed.

JOSEPH M. BENNETT, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Lindstedt & Buono, Attorneys

WCB 86-07730
October 24, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

The noncomplying employer requests review of Referee McCullough's order which: (1) found that claimant was a subject worker; and (2) set aside the SAIF Corporation's denial, issued on behalf of the employer, of claimant's claim for a left knee injury. On review, the employer contends that claimant was not a subject worker.

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

Claimant was familiar with Church's bingo operations and had performed services for Church on one occasion before February 25, 1986. (Tr. pgs. 44 & 46). Claimant performed services for Church on February 25, 1986. He did not consider himself to be a volunteer, but had the expectation of receiving remuneration in the form of a coupon for bingo cards and refreshments. (Tr. pgs. 49 & 65). Once claimant agreed to provide services for Church on February 25, 1986, Church advised claimant of when to be at a particular location and assigned him specific duties. (Tr. pgs. 49 & 50).

We agree with the Referee that the facts establish an implied contract of employment between claimant and Church.

ORDER

The Referee's order dated May 21, 1987, is affirmed. For prevailing on Board review, claimant's attorney is awarded a reasonable assessed fee of $470, payable by the SAIF Corporation on behalf of the noncomplying employer.

DOROTHY L. BURCH, Claimant
Quintin B. Estell, Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 85-00012
December 7, 1989
Order on Review

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee Huff's order that: (1) declined to reopen the record for the admission of another exhibit; and (2) affirmed an award by Determination Order of 15 percent (48 degrees) unscheduled permanent partial disability for her low back. On review, the issues are remand for the admission of the exhibit and extent. We decline to remand and affirm.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following supplementation. Claimant injured her low back on May 21, 1984 and her neck in a separate accident on December 2, 1985. Exhibit 40 is a medical report by Dr. Stanley, an orthopedic surgeon. The report is addressed to SAIF and is dated January 11, 1988. It was received by SAIF on January 14, 1988. SAIF forwarded a copy of the report to claimant's attorney on January 19, 1988 along with a cover letter which incorrectly referenced the claim and WCB case numbers associated with

claimant's neck injury. Claimant received the cover letter and the associated copy of Dr. Stanley's report on January 20, 1988.

The hearing was held on February 1, 1988. Exhibits 1 through 39 were admitted without objection at the beginning of the hearing. After the hearing but before the Referee issued his order, claimant's counsel discovered that the report incorrectly designated by SAIF as relating to claimant's neck claim actually related to her low back claim. He submitted a copy of the report to the Referee on February 17, 1988 and requested that it be included in the record as Exhibit 40. SAIF objected on the ground that the record had been closed at the time of the hearing. The Referee refused to reopen the record for purposes of admitting the exhibit.

Claimant was 55 years old at the time of the hearing. She has a GED and about one year of college. Her work history includes jobs as a nurse's aide, hotel maid and a service aide with the employer at the time of injury. Dr. Becker, a consulting orthopedic surgeon, rated claimant's low back impairment at between 12 and 15 percent.

FINDINGS OF ULTIMATE FACT

1. Without the inclusion of Exhibit 40 into the record, the case has not been improperly, incompletely, or otherwise insufficiently developed.

2. Claimant sustained mild impairment to her low back as a result of her May 1984 injury.

CONCLUSIONS OF LAW

Remand

We treat claimant's contention that the Referee should have reopened the record for submission of Exhibit 40 as a motion to remand for the taking of additional evidence. Consequently, we have reviewed the exhibit for purposes of determining whether its absence from the record renders the case improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). We conclude that the record, without the inclusion of the aforementioned exhibit, has been properly, completely and sufficiently developed to permit us to determine the extent of claimant's permanent disability resulting from her compensable low back injury. Accordingly, we decline to remand.

Extent of Low Back Disability

The Board adopts the Referee's "Opinion" as its conclusions of law on the extent issue with the following comment. Considering claimant's mild low back impairment along with the social and vocational factors set forth in former OAR 436-30-380 et seq., we conclude that the award by Determination Order of 15 percent (48 degrees) adequately and appropriately compensates claimant for the permanent loss of earning capacity due to her low back condition.

ORDER

The Referee's order dated February 29, 1988 is affirmed.

GERALD C. CASEY, Claimant
Irene B. Taylor, Claimant's Attorney
Bottini, et al., Defense Attorneys

WCB 87-19230
December 7, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Seymour's order which upheld the self-insured employer's denial of his back, neck, right shoulder and right arm injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On October 5, 1987, claimant and Gary Tschanz were employed by the same employer. At the time of the incident, both claimant and Tschanz were in the process of delivering a drum of chemicals to the chemical room, at the plant where they worked.

The chemical room is a room in which liquid chemicals, stored in 55 gallon plastic containers, each weighing approximately 400 to 500 pounds, are kept. The drums are stored lengthwise on two parallel steel tracks, each approximately four inches across, two feet apart and approximately two feet off the floor. The rails run the length of one wall in the chemical room. After the drums are rolled onto the tracks, they are kept in place with pieces of 2 X 4 placed on either side of the drum. The spigots on each drum are placed downward so that the contents of the drum may be drained into a bucket for use.

At one end of the chemical room and rails is a window through which the drums are transferred from the outside of the room into the room. The window is the width of the drum plus the spigot, plus one or two inches tolerance from the combined length. The bottom of the window is the same height from the floor as the rails. The window has approximately two feet of clearance above the height of a drum.

The method of placing a drum into the chemical room is to place the drum crosswise on a forklift, move the forklift in front of the window, raise the forklift so that it is slightly above the window, and tilt the forklift post forward, thereby allowing the drum to roll down the incline of the forks, through the window and immediately onto the rails. A full container will mold itself around the forks of the forklift owing to the weight of the contents of the drum.

At the time of the accident, Tschanz was in the chemical room and claimant was operating the forklift, both in the process of transferring a drum from the outside into the chemical room. As Tschanz was guiding the drum toward the rails on which the drum was to be placed, he slipped, and while continuing to hold onto the drum, fell onto his tailbone. The drum rolled off the rails and onto his chest.

Claimant got off the forklift and entered the chemical room. Claimant straddled Tschanz and with the assistance of Tschanz, lifted the barrel off of Tschanz and placed the drum on the rack. Within minutes of the accident, a secretary, after hearing a crash, ran into the chemical room and saw Tschanz on the floor and a bucket of liquid spilled. Claimant did not return to work after the incident because his shift was over. Claimant noticed immediate onset of back pain the following morning when getting out of bed. Claimant did not report an injury or seek medical treatment until the following day.

Claimant submitted a claim to his employer the following day, October 6, 1987. On October 6, 1987, claimant visited Dr. Berg, who diagnosed acute muscle strain of the back and treated claimant with pain pills, muscle relaxants, rest and heat. On October 8, 1987, claimant was seen by Dr. Nelson, who diagnosed acute muscle strain of the back and treated claimant conservatively with medication, rest and heat. Dr. Nelson's medical report of October 8, 1987, noted that claimant was not medically stationary and that claimant's condition was work related.

On October 12, 1987, claimant again visited Dr. Nelson who continued claimant's treatment of pain medicine and muscle relaxants with no release to work. Claimant was still medically not stationary.

Claimant suffered an acute back sprain on the job on October 5, 1987.

CONCLUSIONS OF LAW

The Referee concluded that claimant's back injury claim not compensable because he found neither claimant nor Tschanz to be credible witnesses. He also reasoned that there was no objective medical findings of injury.

In exercising de novo review we generally defer to a Referee's assessment of credibility when his or her finding is based on demeanor. Humphrey v. SAIF, 58 Or App 360, 363 (1982); Robert W. Cooper, 40 Van Natta 486 (1988). In this case, the Referee did not base his findings on claimant's demeanor, but on the substance of the witnesses' testimony. When the Referee's credibility finding is based on the substance of the witnesses' testimony, rather than the witnesses' demeanor, we are equally capable of assessing credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

In the present case, after reviewing the substance of various witnesses' testimony, we disagree with the Referee's conclusions. The Referee was concerned about the following portions of the record: (1) the mechanism of the injury, in that he found it difficult to believe that the claimant and Tschanz could lift a four or five hundred pound drum onto the rails in the manner in which they stated; (2) Tschanz's story to the supervisor regarding the mechanics of the injury; (3) the condition of the plastic drum after the incident; (4) the physical evidence which convinced him that given the description of the incident, the drum would have fallen between the rails and not in front of Tschanz; (5) Tschanz's alleged failure to tell anyone who came on the scene that a drum fell on top of him; and (6) the condition of Tschanz's shirt after the incident.

We address the Referee's concerns in order.

(1) Both claimant and Tschanz were employed to work in sanitation. On occasion, claimant, with the assistance of another individual, has lifted the four to five hundred-pound drums onto various surfaces, such as trucks or a ramp. One witness, May, testified that he felt it was possible for a 400 to 500 pound drum to be moved if the individuals were strong. Claimant is used to and accustomed to heavy physical labor which involves the lifting and moving of the drums in question. Given these facts, we find it

reasonable to conclude that claimant and Tschanz could have lifted the drum onto the shelf in the manner they stated.

(2) The second concern of the Referee relates to Tschanz's story to the supervisor. The Referee stated that "when Ray Wilbanks came into the room immediately afterwards, Tschanz's story was that he was standing between the rails, and was pulling the drum forward toward him, when he was pinned between the drum coming off the forklifts, and a drum of ammonia, which was already on the rack."

However, our review indicates that Wilbanks testified only as to his "impression" as to what happened. Wilbanks did not testify that Tschanz told him that he was standing between the rails, nor did he testify that the drum Tschanz supposedly was pinned against was ammonia. Wilbanks continually testified to his vague memory of the incident: "I think", "my impression", "I can't remember". Considering Wilbanks' poor recollection, we are not persuaded by this portion of his testimony.

Claimant's, as well as Tschanz's, testimony as to how the drum fell is consistent throughout the record. The supervisor's injury report form completed by Tschanz, the first aid record as documented by Jean Hill, the original 801 form filled out by claimant, Dr. Nelson's history report of October 13, 1987, Dr. Lautenbach's October 15, 1987 First Medical Report, and all statements made by claimant to other people on the date of the injury have been consistent. Tschanz reported that as he was helping to unload a 55 gallon barrel from a forklift, the barrel started rolling toward him, and as he was trying to guide the barrel onto the ramp, he slipped, grabbing onto the barrel to prevent it from falling on him, and landed on a 2 X 4 with the barrel on top of him.

Because Wilbanks' recollection of what happened that night is vague, at best, his testimony concerning this issue is given little weight. And, because Tschanz's testimony is consistent throughout the record, but for Wilbanks' testimony, we give Tschanz's testimony more weight.

(3) The Referee concluded that, "the drum was made of soft plastic, and the believable testimony of other witnesses was that any plastic drum which is pushed crossways on the rails, would have scratch marks on it. Claimant and Tschanz contend that they pushed the drum crossways on the rails. The believable evidence was that there was no scratch marks on the drums indicating such movement."

The Referee based his opinion on his belief that claimant and Tschanz testified as to the crosswise placement of the barrel. Neither claimant nor Tschanz testified that the drum was pushed crossways on the rails. Both claimant and Tschanz indicated that the barrel was raised and "sort of slid" onto the rail. Claimant and Tschanz testified that the incident occurred in a matter of seconds.

Roger Sackman, a credible witness, testified that, "the label had marks on it like slight tear marks out to the point where it was resting on the angle iron". Sackman went on to state that, I could see that it [the barrel] had rolled to the position it was in. I could see no evidence that it was slid."

The record is unclear as to the exact way the barrel was placed on the ramp. Claimant testified that the barrel was "just kind of picked up, soon as it got there, just the slide motion over there." It was employer/insurer's attorney who indicated that the barrel was "slid into place", not claimant. The discrepancy between the claimant's testimony regarding the placement of the barrel and Sackman's testimony as to the results when barrels are moved in certain types of ways is not critical. The label was torn, which indicates movement of the barrel, but no distinct scratch marks were seen by Sackman. Both claimant and Tschanz indicated that due to the urgency of the situation, they merely used their strength to place the barrel in its appropriate place. We do not consider the manner in which the barrel was returned to be critical. Thus, this discrepancy is not fatal to claimant's claim.

(4) The Referee was persuaded by physical evidence that if the end of the drum nearest the wall had, in fact, gone off the rack, it would have fallen in between the rails, and not in front of Tschanz, as contended by claimant and Tschanz. We disagree. The record does not include such physical evidence to determine whether, in a given situation, a certain outcome would result. However, Wilbanks testified that if the forklift were slanted at an angle, thereby causing the barrel to begin to fall, there "maybe" sufficient force to cause the barrel to not fall over the rails and fall on claimant as claimant asserts. This testimony, in conjunction with that of claimant and Tschanz, persuades us that the drum fell as claimant contends.

(5) The Referee did not believe Tschanz's version of events because he did not tell anyone who came in to the scene that a drum fell on top of him. Claimant may not have verbally told anyone on the scene that the drum fell on him. The record does indicate, though indirectly, that claimant informed his supervisor and the first aid nurse in completing the requisite employee accident forms. Again, the 801 form, the supervisor's injury report and the nurse's notes indicate that Tschanz indicated that a barrel did fall on him. The contention that Tschanz failed to verbally indicate that a barrel had fallen on him does not prompt us to conclude that the barrel never fell on him.

(6) Finally, Tschanz contended that a bucket of chlorine fell and soaked his shirt, while the first aid attendant contended that there was almost no chlorine on his clothes. The issue of the amount of chlorine on Tschanz's clothes has no relevance to the determination of whether claimant hurt his back while lifting a barrel off of Tschanz. Therefore, we find Referee's sixth contention unnecessary to discuss.

The facts favorable to claimant's case are these: (1) the secretary on the work site heard a crashing sound, and after investigation called for the supervisor; (2) claimant's testimony at the hearing was entirely consistent with the reports he submitted to both his employer and his physicians; (3) claimant's treating physician diagnosed claimant's injury as acute back sprain and treated claimant conservatively with medication; (4) claimant's treating physician noted that claimant's condition was work related; and (5) there has been no alternative explanation for claimant's injury.

The aforementioned facts support claimant's back injury

claim. This support, coupled with the Referee's unpersuasive credibility finding, and the explanation for the inconsistencies relating to the manner in which the barrel was placed after the accident, leads us to conclude that the claim is compensable.

ORDER

The Referee's order, dated June 1, 1988, is reversed. The self-insured employer's denial is set aside and it is instructed to accept the claim and process it according to the law. For services at the hearing and on Board review, claimant's attorney is awarded a reasonable assessed fee of $2,500. A client-paid fee, not to exceed $2,016, is approved.

BARBARA J. DANIELS, Claimant
Galton, et al., Claimant's Attorneys
Carrol J. Smith (SAIF), Defense Attorney

WCB 88-00183
December 7, 1989
Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of that portion of Referee Mulder's order that rejected her request for an award of permanent total disability in connection with her claim for an injury to her right knee. The issue is extent of disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following additions.

Claimant injured her right knee on January 13, 1985. She first developed symptoms in her low back about a month later. These symptoms worsened in April 1986. Degenerative spondylosis was diagnosed. This condition preexisted claimant's right knee injury, but was asymptomatic until after the injury. SAIF denied the compensability of claimant's low back condition in August 1986. In May 1987, the parties entered into a disputed claim settlement of the condition.

CONCLUSIONS OF LAW

The Board adopts the Referee's conclusions of law with the following supplementation.

Permanent total disability means "the loss, including preexisting disability, of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a). Claimant contends that her lumbar spondylosis is a "preexisting disability" for purposes of the above definition. We disagree. A condition which exists before the industrial injury, but which does not become disabling until after the injury is not a "preexisting disability." Fowler v. SAIF, 82 Or App 604 (1986); Walter R. Searles, 41 Van Natta 627, 628-29 (1989).

ORDER

The Referee's order dated April 19, 1988 is affirmed.

VALENCIA HINDS, Claimant
Francesconi & Associates, Claimant's Attorneys
Meyers & Radler, Defense Attorneys

WCB 88-04436
December 7, 1989
Order on Review (Remanding)

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Knapp's order which dismissed her request for hearing on the basis that she did not appear at the hearing. On review, the issue is dismissal. We vacate and remand.

FINDINGS OF FACT

A Notice of Hearing set this case for hearing on June 6, 1988. Both claimant and her attorney were notified of the hearing date. The hearing was set for 11:00 a.m. Claimant's counsel was present, however, claimant did not appear. By order of June 9, 1988, the Referee dismissed claimant's request for hearing.

Claimant requested reconsideration, submitting a letter from her to her counsel stating that she had misunderstood her counsel and did not think she was required to appear at the hearing. In the letter, she requested her hearing to be rescheduled. On reconsideration, dated July 6, 1988, the Referee concluded that claimant had not established "good cause" for her nonappearance and reinstated his Order of Dismissal.

CONCLUSIONS OF LAW

The Referee dismissed claimant's request for hearing pursuant to former OAR 438-06-071, based on claimant's failure to appear at the hearing. Subsequent to the Referee's decision, the court issued its decision in Williams v. SAIF, 99 Or App 367 (1989). In Williams, the court held, that under the current version of OAR 438-06-071, Referees are not authorized to dismiss a claimant's hearing request simply because claimant did not appear at the hearing. The court reasoned that a claimant was entitled to offer the remainder of her evidence, even if she chose not to testify personally. Id.

The relevant language of the version of OAR 438-06-071 in effect at the time of the hearing in the instant case, and the current version cited by the court in Williams, is substantially the same. Both rules provide that if a party or the party's attorney fail to appear at the hearing, then that failure to appear is a waiver of appearance and is grounds for dismissal if the party waiving requested the hearing. See Mark S. Lesowske, 41 Van Natta 2154 (November 28, 1989).

Here, although claimant did not appear at the hearing, her attorney was present. In accordance with the Williams reasoning, claimant's failure to appear is not grounds for dismissal under OAR 438-06-071. Accordingly, we conclude that the hearing request should not have been dismissed.

Although we have found that claimant's hearing request should not have been dismissed, we conclude that she has waived her right to testify. We have recently held that under the rule applicable to this case, a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued as long the Referee retains jurisdiction. Mark R. Luthy, 41 Van Natta 2132 (November 21, 1989).

Here, the Referee correctly treated claimant's motion for reconsideration and letter as a motion of postponement. He found that the letter, which indicated claimant's nonappearance was due to a misunderstanding between herself and her attorney, was insufficient to justify postponement. We agree that the letter does not establish extraordinary circumstances beyond claimant's control sufficient to justify postponement. See former 438-06-081. Claimant waived her right to testify. Pursuant to Williams however, we conclude that the Referee was incorrect to dismiss claimant's case. Claimant's hearing request shall be reinstated and she may present any written and testimonial evidence admitted by the Referee, save for her own testimony which she has waived.

ORDER

The Referee's order, dated June 9, 1988, as reconsidered July 6, 1988 is vacated and the case is remanded to Referee Knapp for further proceedings consistent with this order.

JOYCE A. MORTON, Claimant — WCB 87-04516
W.D. Bates, Jr., Claimant's Attorney — December 7, 1989
Roberts, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Huffman's order that upheld the insurer's denial of her claim for a right ankle injury. On review, the sole issue is compensability.

We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings. In addition, we find that the right ankle condition for which claimant sought treatment was not attributable to reflex sympathetic distrophy, and that claimant does not suffer from demyelinating disease or syringomyelia. We further find that claimant has not demonstrated that she fell at work as she contends.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not carried her burden of proving that her alleged work injury actually occurred. In support of that decision, the Referee noted "discrepancies, large and small, in claimant's various reports of how [and when] the accident occurred, . . . to whom she reported it, and the level of pain and other symptoms she experienced after the alleged fall and up to the time she sought medical treatment in January 1987." The Referee also relied on medical evidence indicating that claimant's current symptoms were probably not attributable to an injury of the type she described.

On review, claimant argues that any discrepancies in her story are insignificant and do not support an adverse credibility finding. She also argues that the Referee improperly relied on causation evidence that claimant contends is neither relevant nor persuasive.

We are not persuaded by claimant's argument that any discrepancies in her account of the injury are minor and of no

significance. Considered as a whole, these inconsistencies create significant doubt about claimant's credibility and were a proper basis for the Referee's adverse credibility finding. At various times, claimant has stated that her injury occurred in August 1986, the second week in October 1986, the last week of October 1986, the first week of November 1986, and the third week of November 1986. She testified that she fell three feet at the time of her alleged injury, but she previously told Dr. Zimmerman that she fell six feet. She told Dr. Schachner that her right ankle and leg pain progressively worsened after her injury, whereas she testified that her condition remained roughly the same.

Furthermore, claimant testified that she made an accident report on the day of the injury, but she told Dr. Herring and the Neurological Consultants that she reported her injury the morning after it occurred. She initially testified that she reported her injury to a nurse named "Willie or Wilma," but she then identified a different nurse as the individual on duty when she made her report. She first reported that there were no witnesses to her accident, but she testified that a co-worker helped her out of the tank after her fall, and that a different individual went with her to report her injury.

Moreover, neither purported witness appeared at trial to verify claimant's story, and the employer had no documented record of the incident. In addition, three of the employer's four nurses testified that they did not recall the alleged injury and would have recorded the incident if it had been reported. Finally, the employer's accident investigator testified that the fourth nurse stated she did not recall the incident. We find no reason to doubt the testimony of the investigator on this particular point.

We turn to claimant's contention that the Referee erred in relying on medical opinion that claimant's current symptoms were not related to her alleged work injury. Claimant first argues that this causation evidence was not relevant to the credibility issue decided by the Referee. We disagree. Evidence that claimant's current symptoms could result from the type of injury she describes would bolster her credibility. Conversely, the absence of such evidence is a factor to be considered in determining whether claimant has carried her burden of proof on this issue.

Finally, we address claimant's alternative argument that the medical evidence relied on by the Referee is not persuasive. The Referee apparently deferred to the opinion of neurologists Leonard and Zivin that the type of injury claimant described would not result in her current symptoms. Claimant contends that the contrary opinions of treating physicians Abraham, Schachner and Herring are more persuasive. Orthopedic surgeon Schachner and neurologist Herring both diagnosed reflex sympathetic dystrophy which they attributed to the alleged injury. Dr. Herring made an additional, tentative diagnosis of injury related demyelinating disease or syringomyelia. The opinion of Dr. Abraham, M.D., is limited to a check in the "work related" box of the Form 827 he submitted to the insurer.

We conclude that the opinions of Drs. Leonard and Zivin are entitled to the greatest weight. Neurologist Herring is not board certified, and Dr. Abraham is a general practitioner. In contrast, both Drs. Leonard and Zivin are board certified

specialists in neurology. Their special expertise is particularly important in this case, where resolution of the causation issue turns on expert analysis, rather than external observation. In such cases, treating physician status is less important than special expertise in the relevant area. See Allie v. SAIF, 79 Or App 284, 287 (1986); Hammons v. Perini Corporation, 43 Or App 299, 301 (1979).

Moreover, Drs. Leonard and Zivin rendered well-reasoned opinions based on a thorough review of claimant's medical history. Both doctors explained that it was unlikely claimant's ankle symptoms in January 1987 were attributable to an alleged injury in October 1986 given the passage of time and the nature of the injury described by claimant. They further explained that claimant's symptomatic history was inconsistent with the diagnoses of reflex sympathetic distrophy, demyelinating disease or syringomyelia. We note that Dr. Herring, himself, ruled out the latter two diagnoses prior to hearing.

Consistent with the above discussion, we conclude that claimant has not demonstrated that she injured herself in a fall at work, as she contends. Accordingly, we affirm the Referee's opinion as supplemented.

ORDER

The Referee's order dated February 23, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $997, for services on Board review.

THEODORE A. MYHRE, Claimant
Karen M. Werner, Claimant's Attorney
Cooney, et al., Defense Attorneys

WCB 88-04305
December 7, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Livesley's order that: (1) upheld the insurer's partial denial of his left carpal tunnel syndrome; and (2) declined to assess a penalty and associated attorney fee for an allegedly unreasonable denial. The issues on review are compensability of the left carpal tunnel syndrome and penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant was compensably injured on February 15, 1984. He reported that a ladder had slipped out from under him and that he had landed on his "rear end and right leg." On June 21, 1984, claimant was seen by Dr. Wasner, a rheumatologist, with complaints of fainting and chest wall pain. Dr. Wasner had seen claimant several times in 1983 for shoulder and chest wall pains. No mention of the February 1984 injury was made to Dr. Wasner.

The first complaints of left arm problems relating to the injury are found in a case history from Dr. Baker, an orthopedist, dated September 10, 1984. Claimant's history of the injury consisted of falling from a ladder and landing in a sitting position with an onset of pain in his back, head, ribs and abdomen, and both arms.

Claimant underwent a lumbar laminectomy at L4-L5,

performed by Dr. Golden, on September 21, 1984. When claimant continued to complain of arm symptoms following surgery, Dr. Golden referred him to Dr. Myers, a neurologist, for EMG studies. The results were normal with no evidence of denervation.

On February 12, 1985, claimant was examined by Dr. Becker, a physiatrist, and gave a history of having fallen from a ladder and landing on his buttocks and low back. On March 24, 1986, claimant provided a history of the injury to the Northwest Pain Center, in which he fell backwards onto his buttocks and left chest. On June 16, 1986, claimant was examined by Dr. Woolpert, an orthopedist. He mentioned nothing about falling on his left hand in February, 1984. Likewise, on March 25, 1987, he gave a history of the injury to Dr. Randle, a neurologist, in which he fell from the ladder and "landed on the left side of his body."

Claimant was seen by Dr. MacRitchie, a physiatrist, on November 3, 1987. At that time, he gave a history of injury consisting of falling on his buttocks. Dr. MacRitchie examined claimant and diagnosed "possible bilateral carpal tunnel syndrome." Subsequent electrodiagnostic studies revealed mild left carpal tunnel syndrome. On February 19, 1988, Dr. MacRitchie was unable to relate the carpal tunnel syndrome to the 1984 injury.

The insurer denied claimant's carpal tunnel syndrome on March 14, 1988. On March 29, 1988, claimant reported to Dr. MacRitchie that he had landed on his hand at the time of the February, 1984 injury.

CONCLUSIONS OF LAW AND OPINION

Compensability

To establish the compensability of his left carpal tunnel syndrome condition, claimant must prove by the preponderance of the evidence that the compensable injury materially contributed to his disability or need for treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). See also Florence v. SAIF, 55 Or App 467 (1982).

It is logical to expect that a worker's recollection of the events involved in an accident would be most clear immediately following the accident. In this instance, claimant provided consistent histories over a four-year period following the February, 1984 accident. Not once during that four-year period did he report a history of falling on his left hand. Only after the carpal tunnel syndrome was denied by the insurer on March 14, 1988, did he state that he landed on his left hand in the February, 1984 accident. After our de novo review, we find claimant to be an unreliable historian.

We turn to the medical evidence. Dr. MacRitchie is the sole physician to support a causal connection between the February, 1984, injury and claimant's carpal tunnel syndrome. Yet, Dr. MacRitchie rendered completely contradictory opinions in the span of little more than one month. See Exs. 236 & 240. On February 19, 1988, MacRitchie stated that a causal connection was "conceivable." She added, however, that "[t]his is all conjecture, since I have not been following [claimant] during the intervening years[.]" Shortly thereafter, on March 29, 1988, she

stated that a causal connection was "quite likely" given claimant's history of falling on his left hand while it was extended. We attach little weight to MacRitchie's latter opinion insofar as we have found that claimant was an unreliable historian. Medical opinion based on an inaccurate history is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Moreover, Dr. MacRitchie's opinion is conclusory and lacks a medical analysis. No reasons are given as to why a condition, which was not present seven months after the injury when Dr. Myers performed the first EMG studies, should be found to be caused by that injury when it appears four years later. In addition, Dr. Wasner's June 1984 report suggests that claimant's problems with shoulder and forearm pain may have existed prior to the injury.

Under such circumstances, claimant has not met his burden of proof. He has not established the compensability of his carpal tunnel syndrome by a preponderance of the evidence.

Penalty and Attorney Fee

Since we have found that claimant's carpal tunnel syndrome is not compensable, we conclude that the insurer's denial was not unreasonable. Accordingly, the assessment of a penalty or attorney fee is not warranted.

ORDER

The Referee's order, dated June 6, 1988, is affirmed. The Board approves a client-paid fee, payable by the insurer to its counsel, not to exceed $1,586.50.

ZENAS A. PERISHO, Claimant — WCB 88-00420
Walter Nunley, Claimant's Attorney — December 7, 1989
Ron Pomeroy (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Howell and Perry.

The SAIF Corporation requests review of that portion of Referee Mills' order that directed it to pay for claimant's proposed back surgery at the L4-5 and L5-S1 levels. SAIF contends on review that the Referee lacked jurisdiction to address the proposed surgery at L4-5 and L5-S1. The issue is jurisdiction. We affirm in part, reverse in part, and vacate a portion of the Referee's order.

FINDINGS OF FACT

On December 9, 1987, Dr. Purtzer requested that SAIF authorize surgery at L3-4. SAIF denied the request by letter dated December 23, 1987. Claimant requested a hearing. Hearing was set for March 22, 1988.

In the interim, claimant continued to undergo examinations by various physicians. Some of these reports indicated the possible involvement of L4-5 and L5-S1 in the causation of at least some of claimant's symptoms. On March 1, 1988, Dr. Dunn gave claimant a sinovertebral block at L5-S1 right. This procedure resulted in 100 percent relief of symptoms for twenty-four hours. By chart note dated March 17, 1988, five

days before hearing, Dr. Dunn opined that a foraminotomy at L5-S1 was recommended.

SAIF received a copy of Dr. Dunn's chart note on the date of hearing. Two days following hearing, SAIF received Dr. Purtzer's response to Dr. Dunn's chart note. In his response, Dr. Purtzer indicated that Dr. Dunn's studies established that claimant's right leg symptoms were caused by defects at L4-5 or L5-S1, rather than a defect at L3-4.

CONCLUSIONS OF LAW AND OPINION

Based upon the reports of Dr. Purtzer and Dr. Dunn, the Referee concluded that SAIF's denial of L3-4 surgery was proper. We agree and adopt the Referee's reasoning in that regard. However, he further concluded that SAIF had "de facto" denied surgery at L4-5 and L5-S1. Relying upon Purtzer's and Dunn's opinions, the Referee set aside SAIF's "de facto" denial of surgery at L4-5 and L5-S1.

ORS 656.262(6) allows an employer/insurer 60 days in which to accept or deny a claim after it has notice or knowledge of the claim. A claim is deemed denied "de facto" after expiration of the 60-day period, if the employer/insurer has not accepted or denied it. Syphers v. K-M Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981). The statutory scheme does not reasonably permit a hearing on the compensability of medical services prior to a timely acceptance or denial or prior to the expiration of the 60-day period established by ORS 656.262(6).

Here, the matter went to hearing on SAIF's denial of surgery at L3-4. SAIF did not have notice or knowledge of the proposed surgery at L4-5 and L5-S1 until the day of hearing. Therefore, the 60-day period had only just commenced to run at the time of hearing. Consequently, the requested surgery at L4-5 and L5-S1 could not have been in "de facto" denied status.

The Referee could nevertheless properly have addressed the compensability of L4-5 and L5-S1 surgery at hearing if claimant had raised that as an issue at hearing and SAIF had neither objected nor requested a continuance. See Thomas v. SAIF, 64 Or App 193 (1983). Claimant's counsel did discuss claimant's L5-S1 condition several times during his opening statement at hearing. However, we do not interpret his remarks as clearly raising L5-S1 surgery as an issue. Cf. Thomas, supra, where claimant's counsel expressly noted that he was raising an alternate theory and that he had discussed the matter with SAIF's attorney prior to hearing. We conclude that the Thomas rationale is not applicable.

Therefore, the Referee lacked jurisdiction to address the question of claimant's proposed L4-5 and L5-S1 surgery.

ORDER

The Referee's order dated April 21, 1988 is affirmed in part, reversed in part, and vacated in part. That portion of the Referee's order that directed the SAIF Corporation to pay for claimant's proposed back surgery at the L4-5 and L5-S1 levels is vacated and dismissed for lack of jurisdiction. The Referee's award of an assessed attorney fee payable by SAIF to claimant's attorney is reversed. The remainder of the Referee's order is affirmed.

BOBBY P. TANKERSLEY, Claimant
Karen M. Werner, Claimant's Attorney
Stafford Hazelett, Defense Attorney
Williams, et al., Defense Attorneys

WCB 87-16562
December 7, 1989
Order on Review

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Galloway's order that upheld the insurer's aggravation denial of his allegedly worsened low back condition. On review, the issue is aggravation.

We review de novo and, for reasons different from those stated in the Referee's order, affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in February, 1986, resulting in a lumbar strain. He was taken off work by Dr. Horniman, M.D., and treated conservatively. In June, 1986, he began to treat with Dr. Berovic, a chiropractor. Berovic treated with regular chiropractic adjustments and released claimant to modified work in October, 1986. The following month, claimant was examined by the Independent Chiropractic Consultants. The Consultants performed a follow-up examination in April, 1987.

A Determination Order closed claimant's claim in May, 1987, with an award of 20 percent unscheduled permanent disability for the low back, and periods of temporary disability.

While continuing to work under a modified work release, claimant allegedly reinjured his low back on July 21, 1987. Later that day, he was examined by Berovic. Berovic noted complaints of increased low back pain and took claimant off work.

On July 29, 1987, the parties entered into a Disputed Claims Settlement, wherein claimant was awarded 10 percent additional unscheduled permanent disability, for a total award of 30 percent.

Claimant was reexamined by the Consultants in October, 1987. The Consultants found no objective change in claimant's low back condition from their earlier examination of April, 1987.

In November, 1987, Berovic released claimant back to modified work.

Claimant did not experience a pathological or symptomatic exacerbation of his low back condition after the May, 1987, Determination Order.

CONCLUSIONS OF LAW

Finding that claimant had proven only a "waxing and waning of symptoms," the Referee concluded that claimant had not proven an aggravation. Although we agree with the Referee that claimant has not proven an aggravation, we do so for different reasons.

A "waxing and waning of symptoms" may or may not result in an aggravation. Gwynn v. SAIF, 304 Or App 345, on rem 91 Or App 84 (1988); Smith v. SAIF, 302 Or App 396 (1986). The

critical inquiry is whether claimant sustained "worsened conditions resulting from the original injury." ORS 656.273(1); Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989). "Worsened conditions" may take the form of either a symptomatic flare-up or a pathological change in the underlying condition. Smith, 302 Or at 401. In addition, the "worsened conditions" must render the worker less able to work than at the time of the last arrangement of compensation. Id. If a symptomatic flare-up, claimant must prove that his flare-up exceeded any flare-up contemplated at the time of the last arrangement of compensation. Gwynn, supra.

As a preliminary matter, we observe that claimant's alleged aggravation occurred before the entry of the Disputed Claims Settlement (i.e., the alleged aggravation occurred on July 21, 1987, and the settlement was entered on July 29, 1987). Accordingly, at the time of claimant's alleged aggravation, the last arrangement of compensation was the May, 1987, Determination Order.

Although Berovic took claimant off work for four months beginning in July, 1987, claimant must prove a worsened condition as a matter of fact. Perry, 307 Or at 657. That factual question must be decided on a case-by-case basis. Id. Here, the medical evidence concerning a worsened condition is divided. The Consultants found no objective medical findings to verify a change in claimant's low back condition. In their view, claimant's subjective complaints of pain did not correspond to objective medical findings. As a result, the Consultants recommended pain center treatment.

Berovic disagreed with the Consultants. In doing so, he stated:

> "I find it interesting that the examination conducted by the Chiropractic Consultants in which they determined the patient did not have an aggravation was done sometime after the patient's acute exacerbation and they have no way of knowing what his condition was between point of exacerbation and date of their examination on October 14, 1987. On October 14, 1987, the patient's condition had markedly improved from his condition following the exacerbation." (Emphasis added).

Berovic's rationale for disagreeing with the Consultants was that claimant's condition had "markedly improved" by the time of their October, 1987, examination. Yet, in his deposition of February, 1988, Berovic repeatedly testified that after the July 21, 1987, Determination Order, "[a]nd from that point on[,]" claimant experienced a worsened condition. For example, Berovic testified:

> "And from that point on[,] we had considerable difficulty with him[.] [H]e was much more unstable. (Ex. 76 pgs. 62-3).
>
> "* * * * *.

"Prior to July 21st of '87, his condition was improving. As of July 21st of 1987, there was a dramatic decline in his condition. He has not yet reached a position consistent with where he was prior to July 21st of 1987. (Ex. 76 pg. 65).

"* * * * *.

"Whatever happened to him on July 21st of 1987 unquestionably caused a deterioration of his condition that has not yet recovered and may not." Id.

We find it illogical, at best, that claimant's condition would worsen in July, 1987, then markedly improve on the date of the Consultants' October, 1987, examination, only to once again worsen thereafter. In sum, we are more persuaded by the Consultants' medical opinion than by Berovic's. The Consultants were in as good a position as Berovic to assess whether claimant's condition had worsened, insofar as they had examined claimant both before and after the May, 1987, Determination Order. See Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986). Because we are not persuaded by Berovic's opinion, we attach little weight to his July, 1987, work release authorization.

Accordingly, on this record, we are not persuaded that claimant experienced a pathological or symptomatic exacerbation rendering him less able to work after the May, 1987, Determination Order. Claimant has not met his burden.

ORDER

The Referee's order, dated May 2, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its former attorney, not to exceed $4,331.25.

JAMES D. TATE, Claimant
Charles Maier, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 86-18044
December 7, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Foster's order that assessed a $500 penalty for its late acceptance of claimant's low back condition.

The Board reverses that portion of the Referee's order that assessed a penalty. All remaining portions of the Referee's order are affirmed.

ISSUE

Whether there were any "amounts [of compensation] then due," with respect to which a penalty could be assessed.

FINDINGS OF FACT

The Board adopts the Referee's findings.

CONCLUSIONS OF LAW

SAIF accepted claimant's injury claim beyond the 60-day period allowed by ORS 656.262(6). Finding that SAIF had unreasonably delayed the payment of compensation, the Referee assessed a $500 penalty.

On review, SAIF argues that the Referee erred in assessing a penalty because there were "no amounts [of compensation] then due." ORS 656.262(10). We agree.

ORS 656.262(6) provides, inter alia:

> "Pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits * * * ." See also Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989).

Here, we find no evidence of compensation due at the time SAIF accepted claimant's low back condition. Moreover, on review, claimant argues that: "The amounts then due are the medical bills not paid and not denied within 60 days after the date of the claim." Claimant's argument is contrary to ORS 656.262(6). See Eastmoreland Hospital v. Reeves, supra. Accordingly, we conclude that a penalty is not properly assessable.

ORDER

The Referee's order, dated April 28, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that assessed a $500 penalty is reversed. All remaining portions of the Referee's order are affirmed.

GARY M. TSCHANZ, Claimant	WCB 87-19218
Irene B. Taylor, Claimant's Attorney	December 7, 1989
Bottini, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Seymour's order which upheld the self-insured employer's denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On October 5, 1987, claimant and Gerald Casey were employed by the same employer. At the time of the incident, both claimant and Casey were in the process of delivering a drum of chemicals to the chemical room at the plant where they worked.

The chemical room is a room in which liquid chemicals, stored in 55 gallon plastic containers, each weighing approximately 400 to 500 pounds, are kept. The drums are stored lengthwise on two parallel steel tracks, each approximately four inches across, two feet apart and approximately two feet off the floor. The rails run the length of one wall in the chemical room. After the drums are rolled onto the tracks, they are kept in place with pieces of 2 X 4 placed on either side of the drum. The spigots on each drum are placed downward so that the contents of the drum may be drained into a bucket for use.

At one end of the chemical room and rails is a window through which the drums are transferred from the outside of the room into the room. The window is the width of the drum plus the spigot, plus one or two inches tolerance from the combined length. The bottom of the window is the same height from the floor as the rails. The window has approximately two feet of clearance above the height of a drum.

The method of placing a drum into the chemical room is to place the drum crosswise on a forklift, move the forklift in front of the window, raise the forklift so that it is slightly above the window, and tilt the forklift post forward, thereby allowing the drum to roll down the incline of the forks, through the window and immediately onto the rails. A full container will mold itself around the forks of the forklift owing to the weight of the contents of the drum.

At the time of the accident, claimant was in the chemical room and Casey was operating the forklift, both in the process of transferring a drum from the outside into the chemical room. As claimant was guiding the drum toward the rails on which the drum was to be placed, claimant slipped, and while continuing to hold onto the drum, fell onto his tailbone. The drum rolled off the rails and onto his chest. Claimant fell onto one of the 2 X 4's and, as he fell, knocked over a bucket of chlorine.

Casey got off the forklift and entered the chemical room. Casey straddled claimant and with claimant pushing up on the barrel placed the drum on the rack. Within minutes of the accident, a secretary, after hearing a crash, ran into the chemical room and saw claimant on the floor and a bucket of liquid spilled.

On the same evening as the work incident, claimant completed, signed and dated a supervisor's injury report, indicating the above-stated facts. The next day, claimant visited his physician, Dr. Lautenbach, complaining of severe lower left back pain. The treating physician diagnosed acute thoracic strain and treated claimant's condition conservatively with medicine, ultrasound and muscle relaxants. On October 9, 1987, claimant requested and obtained a leave of absence from Norpac.

Claimant sought treatment from Dr. Kelley, chiropractor. On October 26, 1987, Kelley diagnosed acute traumatic cervicothoracic and lumbar strain. On November 4, 1987, Kelley reported that claimant's temporary total disability would continue for four to six weeks.

On December 14, 1987, the employer denied claimant's lower left back condition.

Claimant suffered a lower back sprain on the job on October 5, 1987.

CONCLUSIONS OF LAW

The Referee found claimant's low back injury claim not compensable because he didn't find claimant's and Casey's testimony to be believable. He also reasoned that there was no objective findings of injury. The Referee found claimant not credible.

In exercising de novo review we generally defer to a Referee's assessment of credibility when his or her finding is based on demeanor. Humphrey v. SAIF, 58 Or App 360, 363 (1982); Robert W. Cooper, 40 Van Natta 486 (1988). In this case, the Referee did not base his findings on claimant's demeanor, but on the substance of the witnesses' testimony. When the Referee's credibility finding is based on the substance of the witnesses' testimony, rather than the witnesses' demeanor, we are equally capable of assessing credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

In the present case, after reviewing the substance of various witnesses' testimony, we disagree with the Referee's conclusions. The Referee was concerned about the following portions of the record: (1) the mechanism of the injury, in that the Referee personally found it difficult to believe that the two individuals could lift a four or five hundred pound drum onto the rails in the manner in which they stated; (2) claimant's story as to how the incident occurred as reported to claimant's supervisor; (3) the condition of the plastic drum after the incident; (4) the physical evidence which convinced him that given the description of the incident, the drum would have fallen between the rails and not in front of claimant; (5) claimant's alleged failure to tell anyone who came on the scene that a drum fell on top of him; and (6) the condition of claimant's shirt after the incident.

We address the Referee's concerns in order.

(1) Both claimant and Casey were employed to work in sanitation. On occasion, Casey, with the assistance of another individual, has lifted the four to five hundred-pound drums onto various surfaces, such as trucks or a ramp. One witness, May, testified that he felt it was possible for a 400 to 500 pound drum to be moved if the individuals were strong. Claimant and Casey both are used to and accustomed to heavy physical labor which involves the lifting and moving of the drums in question. Given these facts, we find it reasonable to conclude that the two individuals could have lifted the drum onto the shelf in the manner they stated.

(2) The Referee stated that "when Ray Wilbanks came into the room immediately afterwards, claimant's story was that he was standing between the rails, and was pulling the drum forward toward him, when he was pinned between the drum coming off the forklifts, and a drum of ammonia, which was already on the rack."

However, our review indicates that Wilbanks testified only as to his "impression" as to what happened. Wilbanks did not testify that claimant told him that he was standing between the rails, nor did he testify that the drum claimant supposedly was pinned against was ammonia. Wilbanks continually testified to his vague memory of the incident: "I think", "my impression", "I can't remember". Given Wilbanks' poor recollection, we are not persuaded by his speculative testimony.

Claimant's testimony as to how the drum fell is consistent throughout the record. The supervisor's injury report form completed by claimant, the first aid record as documented by Jean Hill, the original 801 form filled out by claimant, Dr. Nelson's history report of October 13, 1987, Dr. Lautenbach's

October 15, 1987 First Medical Report, and all statements made by claimant to other people on the date of the injury have been consistent. Claimant reported that as he was helping to unload a 55 gallon barrel from a forklift, the barrel started rolling toward him, and as he was trying to guide the barrel onto the ramp, he slipped, grabbing onto the barrel to prevent if from falling on him, and landed on a 2 X 4 with the barrel on top of him.

Because Wilbanks' recollection of what happened that night is vague, at best, his testimony concerning this issue is given little weight. And, because claimant's testimony is consistent throughout the record, we give claimant's testimony more weight.

(3) The Referee concluded that "the drum was made of soft plastic, and the believable testimony of other witnesses was that any plastic drum which is pushed crossways on the rails, would have scratch marks on it. Claimant and Casey contend that they pushed the drum crossways on the rails. The believable evidence was that there were no scratch marks on the drums indicating such movement." Both claimant and Casey testified that the incident occurred in a matter of seconds. The record is unclear as to the exact way the barrel was placed on the ramp. The discrepancy between claimant's testimony regarding the placement of the barrel and the other witnesses' testimony as to the results when barrels are moved in certain types of ways is not critical. Both claimant and Casey indicated that due to the urgency of the situation, they merely used their strength to place the barrel in its appropriate place. We do not consider the manner in which the barrel was returned to be critical. Thus, this apparent discrepancy is not fatal to claimant's claim.

(4) The Referee was convinced by physical evidence that if the end of the drum nearest the wall had in fact gone off the rack, the end of the drum toward the wall would fall in between the rails, and not in front of claimant, as contended by claimant and Casey. We disagree. The record does not include such physical evidence to determine whether, in a given situation, a certain outcome would result. However, Wilbanks' testimony does indicate that if the forklift were slanted at an angle, thereby causing the barrel to begin to fall, there "maybe" sufficient force to cause the barrel to not fall over the rails and fall on claimant as claimant asserts. Based on this testimony, in conjunction with claimant and Casey, we are persuaded that the drum fell as claimant contends.

(5) The Referee did not believe claimant's version of events because claimant did not tell anyone who came in to the scene that a drum fell on top of him. Claimant may not have verbally told anyone on the scene that the drum fell on him. The record does indicate, though indirectly, that claimant informed his supervisor and the first aid nurse in completing the requisite employee accident forms. Again, the 801 form, the supervisor's injury report and the nurse's notes indicate that claimant indicated that a barrel did fall on him. The contention that claimant failed to verbally indicate that a barrel had fallen on him does not prompt us to conclude that the barrel never fell on him.

(6) Finally, claimant contended that a bucket of

chlorine fell and soaked his shirt, while the first aid attendant stated that there was almost no chlorine on the claimant's clothes. Casey testified that immediately after the incident claimant's shirt had chlorine on it and that he took claimant's shirt off prior to the first aid attendant coming on the scene. Claimant testified that Casey's girl friend came on the scene prior to the first aid attendant and that the girl friend retrieved from claimant's car another shirt. Casey testified that claimant had more than one shirt on at the time of the incident. Even the notes of the first aid attendant show that claimant did have chlorine on his shirt. We consider the amount of chlorine on claimant's shirt to be of limited assistance to us in determining whether or not an injury did in fact occur. Testimony from more than one witness indicated that a bucket of chlorine did spill onto the floor of the chemical room.

To summarize, the facts favorable to claimant's case are these: (1) the secretary on the work site heard a crashing noise and after investigation found both claimant and a drum on the floor of the chemical room; (2) claimant's testimony at the hearing was consistent with the reports he submitted to both his employer and his physicians; (3) claimant's treating physician diagnosed claimant's injury as acute thoracic sprain and treated claimant with painkillers and muscle relaxants; (4) claimant's treating physician indicated that "the mode of injury would be consistent with this type of problem" and that claimant's condition was work related; and (5) there has been no alternative explanation for claimant's injury.

The aforementioned facts support claimant's lower back injury claim. This support, coupled with the above explanations for the few inconsistencies in the record, leads us to conclude that the claim is compensable.

ORDER

The Referee's order, dated June 1, 1988, is reversed. The self-insured employer's denial is set aside and the claim remanded to the employer for processing according to law. For services at the hearing and on Board review, claimant's attorney is awarded $2,250, to be paid by the employer. A client-paid fee, not to exceed $532, is approved.

JULE VANLAAR, Claimant	WCB 87-14894
Coons & Cole, Claimant's Attorneys	December 7, 1989
Roy Miller (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee McGeorge's order which: (1) found that claimant was not a subject worker; and (2) upheld the SAIF Corporation's denial of his back injury claim. On review, the issue is whether claimant was a subject worker for SAIF's insured. We affirm.

FINDINGS OF FACT

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

Claimant originally agreed to move Dr. Day's office furnishings from one location to another. Subsequently, after it

was determined that a temporary office space would be required, claimant took it upon himself to obtain the necessary information and submit a proposal for the space to the doctor.

Claimant was paid at the rate of five dollars per hour.

Claimant was not credible with respect to the issue of the "Service Agreement" he allegedly prepared.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the conclusion of the Referee with the following modification of the reasoning.

Claimant has the burden to prove, by a preponderance of the evidence, that an employer/employee relationship exists. The test for determining who is a subject worker is the employer's right to control the performance of the services. The test requires an application of the traditional "right to control" analysis and a consideration of the "nature of the work." Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989); Woody v. Waibel, 276 Or 189 (1976).

The traditional right to control analysis consists of the following factors: (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. Castle Homes, Inc., supra, 95 Or App at 272; Marcum v. SAIF, 29 Or App 843 (1977). Here, claimant was paid on an hourly basis and either party could terminate employment without liability. These factors support a finding of claimant being an employee of Dr. Day.

On the other hand, claimant furnished his own tools, a factor indicative of claimant being an independent contractor. Further, direct evidence of the right to control (and/or the exercise of control) is notably lacking. In this regard, claimant was originally hired only to move furniture; he then proposed the need for a temporary office space and drew up the plans without direction from Dr. Day. Claimant had keys to the building and could work any hours he chose. The doctor was only present at the building site for half a day when he arrived to see patients. Claimant was often not present when the doctor arrived because he did most of his work at night or after the staff had left. All the details of construction were left to claimant because the structure was temporary. Dr. Day only exercised enough control to insure that the job got done. See Marcum v. SAIF, 29 Or App at 846. This is insufficient evidence to establish control.

Although a close question, we conclude that application of the control test indicates that claimant is an independent contractor. Moreover, consideration of the "relative nature of the work test" adds support to that conclusion.

Here, the alleged employer's work is that of a medical doctor. Claimant was hired first to move furniture from one office to another, and then, at his own suggestion, to build temporary office space. Dr. Day did not contemplate hiring claimant on a protracted basis. Indeed, the doctor and claimant both testified that claimant was free to submit a bid for the building of the permanent office building, but claimant failed to do so. It has been noted that "when the job to be done is one

that becomes necessary at unpredictable intervals, and when it is not a protracted one, a specialist called in to handle the particular repair or installation is an independent contractor." Marcum v. SAIF, 29 Or App at 848-49.

We conclude, for the previously stated reasons, that claimant was not an employee of Dr. Day.

ORDER

The Referee's order dated November 20, 1987 is affirmed.

ELLEN L. WONCH, Claimant
Peter E. Baer, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-14550
December 7, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Bennett's order that: (1) found that claimant's claim for a hernia condition was not prematurely closed by Determination Order; and (2) affirmed a Determination Order that did not award permanent disability compensation. The insurer cross-requests review of that portion of the Referee's order that set aside its partial denial of claimant's psychological condition. The issues are compensability, premature closure and extent of permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Opinion with the following comment on the premature closure issue.

As correctly noted by the Referee, medical evidence generated after claim closure which refers to claimant's post-closure condition may be considered in determining whether claimant was medically stationary at closure if the evidence establishes that claimant's condition has either not changed or has improved since closure. Scheuning v. J. R. Simplot & Co., 84 Or App 622 (1987); Utrera v. Department of General Services, 89 r App 114 (1987).

The Referee found a lack of persuasive evidence regarding claimant's psychological condition before claim closure. Consequently, he stated that he was unable to compare claimant's psychological condition at closure to her psychological condition post-closure to determine whether claimant had improved, worsened, or remained unchanged. In fact, the Referee interpreted the evidence to suggest that claimant's condition had significantly worsened after closure.

Our review of the record does not support this latter finding of a post-closure worsening. At the same time, the record does not support a finding that claimant's condition either remained the same or improved post-closure. In sum, we agree with the Referee's conclusion that the evidence does not establish how claimant's condition at closure compared with her condition two months later when Dr. Hughes found her not medically stationary on

a psychological basis. Therefore, claimant has failed to sustain her burden of proving that she was not medically stationary as of the date of closure.

ORDER

The Referee's order dated March 16, 1988 is affirmed. Claimant's attorney is awarded an assessed fee for prevailing on the partial denial issue of $700, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $1,454.

JASON L. BAIL, Claimant — WCB 87-15445
Olson, et al., Claimant's Attorneys — December 8, 1989
Terrall & Miller, Defense Attorneys — Order on Review
Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Huff's order that: (1) awarded claimant 5 percent (16 degrees) unscheduled permanent partial disability for a low back condition, whereas a Determination Order had awarded no unscheduled permanent disability; (2) declined to award additional temporary disability compensation; and (3) declined to assess a penalty and associated attorney fee for the self-insured employer's alleged unreasonable refusal to pay temporary disability compensation awarded by Determination Order. The employer cross-requests review of those portions of the Referee's order that: (1) increased claimant's unscheduled permanent disability award; (2) awarded claimant interim compensation; and (3) set aside its denial of claimant's current medical treatment for his low back condition. We reverse on all issues.

ISSUES

1. Medical Services.

2. Interim Compensation.

3. Temporary Disability Compensation.

4. Extent of Permanent Unscheduled Disability.

5. Penalties and Attorney Fees.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact commencing on page 2 of his order and continuing through the second full paragraph on page 3 of his order. We also adopt the last full paragraph on page 6 of the order. In addition, we make the following supplemental findings.

Claimant sought no medical treatment for his low back between August 21, 1986 and July 25, 1987.

Claimant commenced treatment with Dr. Holtan, chiropractor, on August 31, 1987. He initially treated with Dr. Holtan twice per week. As of the date of hearing, this had been reduced to once every two weeks.

The employer issued a medical services denial on September 10, 1987, stating that the current condition and need for treatment was unrelated to the compensable injury and was not reasonable or necessary in the recovery from claimant's injury.

FINDINGS OF ULTIMATE FACT

The employer did not pay temporary disability benefits to claimant for the period from August 8, 1986 through September 10, 1987.

Dr. Holtan's chiropractic treatments are neither reasonable and necessary nor related to the compensable injury.

Claimant has no permanent low back impairment as a result of the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee relied upon claimant's testimony and Dr. Holtan's reports in reaching his conclusion that claimant's chiropractic treatments were reasonable and necessary and related to his compensable condition. However, on de novo review, we are not persuaded on this issue.

Claimant underwent no treatment between August 1986 and July 1987. During that time, claimant worked on a Christmas tree farm, participated in a summer bowling league, and did some painting with a friend. When seen by BBV, claimant indicated that his overall symptoms were much better than they were one year ago and had been the same for several months. In addition, Dr. Tsai, a consulting neurologist, reported that the Christmas tree farm job was difficult. Claimant's ability to participate in such activities without treatment diminishes the persuasiveness of Dr. Holtan's opinion that claimant's treatments are reasonable and necessary and related to his compensable injury.

Moreover, while claimant testified that his condition improved as a result of Dr. Holtan's treatments, Dr. Langston, orthopedic surgeon, reported on November 19, 1987 that claimant stated that the treatments were of no benefit. Dr. Langston also reported that claimant's compensable condition had resolved. In addition, Dr. Buza, neurologist, reported on October 13, 1987 that claimant presented no objective, neurological, or orthopedic findings. Further, claimant testified that he experienced no change in his condition during the two-week period between his regularly scheduled treatments with Dr. Holtan. He further testified that Dr. Holtan was merely "monitoring the situation" to ensure that claimant's back remained stable. Given claimant's long period of time without treatment, combined with his strenuous physical activity during that time, we are not persuaded that Dr. Holtan's regularly scheduled treatments are either related to claimant's original compensable condition or needed to assure that claimant's back remains stable.

Interim Compensation

The employer paid claimant interim compensation for the period up to August 8, 1986. The Referee awarded claimant additional interim compensation for the period from August 8, 1986 through August 10, 1986. The Referee reasoned that claimant was entitled to interim compensation until he was notified by the employer of the denial of his claim. He further found that the

liability of the employer for interim compensation was not affected by claimant's termination from his employment on August 8, 1986.

Claimant made his claim on July 28, 1986. The employer had notice of the claim on the same day. The employer denied the claim on August 11, 1986. Thus, the employer issued its denial within 14 days after notice of the claim. Under these circumstances, no interim compensation was due. See ORS 656.262(2) and (4); Darrell Messinger, 35 Van Natta 161, 166 (1983). Therefore, the Referee's award of interim compensation was incorrect.

Temporary Disability Compensation

Pursuant to the November 27, 1987 Determination Order, the employer was directed to pay temporary disability benefits to claimant for the period July 28, 1986 through September 10, 1987, less time worked. This award was to be paid no later than the 14th day after issuance of the Determination Order. ORS 656.262(4); OAR 436-60-150(3)(e). It was not paid. Claimant contends that the employer improperly refused to pay the award. The employer contends that the award itself was improper.

The appropriate remedy when a party believes that a Determination Order is incorrect is to either request reconsideration of the Determination Order or to request a hearing on the order. ORS 656.268(4). Here, a hearing at which claimant's entitlement to temporary disability benefits was an issue had already been scheduled as of the date of the Determination Order. Consequently, there was no need for the employer to request a hearing challenging the Determination Order's award of temporary benefits. Nevertheless, the fact that claimant's entitlement to temporary disability benefits was scheduled for hearing does not relieve an employer of responsibility for payment of benefits awarded by Determination Order. Rather, compensation awarded in a Determination Order must be paid pending a hearing on entitlement to that award. See Georgia-Pacific v. Piwowar, 305 Or 494, 503 (1988) (involving an award of permanent disability benefits). Accordingly, claimant is entitled to payment of the temporary disability benefits awarded by the November 27, 1987 Determination Order.

Having so concluded, we turn to an examination of claimant's substantive entitlement to temporary disability benefits. Claimant is substantively entitled to temporary disability benefits only for that period during which he lost wages because of an inability to work as a result of his compensable condition. Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987). Claimant was fired on August 8, 1986. The question we must answer is whether claimant was away from work thereafter because of his compensable injury or because he was terminated for reasons not related to his compensable injury. See Nix v. SAIF, 80 Or App 656 (1986).

Dr. Johanson gave claimant a full work release on August 8, 1986. This is evidence, although not conclusive evidence, that despite his injury claimant was able to work as of August 8, 1986. See Fazzolari v. United Beer Distributors, 91 Or App 592, 595, rev den 307 Or 236 (1988). The remaining evidence regarding claimant's ability to perform his regular job duties after August 8, 1986 is in conflict. On August 20, 1986,

Dr. Mertens reported that claimant was in excellent condition and that he had no back impairment. On the other hand, Dr. Tsai did not feel claimant was capable of returning to his at-injury employment. This opinion was apparently based solely upon claimant's complaints of low back tenderness.

We are more persuaded by the opinions of Dr. Johanson and Dr. Mertens than Dr. Tsai. Dr. Johanson was claimant's initial treating physician for his low back condition. Her opinion is, therefore, entitled to considerable deference. Weiland v. SAIF, 64 Or App 810 (1983). Dr. Tsai's neurological examination was normal other than claimant's reports of low back tenderness. In addition, claimant was examined by Dr. Buza, neurosurgeon, on referral from his attorney. Dr. Buza reported in October 1987 that claimant's "injury has been nil, and the loss of function is nil." Although this report was issued long after August 1986, we nevertheless find that it diminishes the persuasiveness of Dr. Tsai's contrary opinion. We conclude that claimant was not disabled from work as of August 8, 1986.

In sum, pursuant to the November 27, 1987 Determination Order, the employer was required to pay claimant temporary disability benefits from July 28, 1986 through September 10, 1987. However, claimant was not substantively entitled to any temporary benefits after August 7, 1986, and the Determination Order should be amended to provide for an award of temporary disability from July 28 through August 7, 1986. However, the employer is required to pay the temporary disability as originally ordered by the Determination Order, but is then entitled to an offset for benefits paid after August 7, 1986.

Penalties and Attorney Fees

If an employer or insurer unreasonably delays or refuses to pay compensation, the employer or insurer shall be liable for an additional amount up to 25 percent of the amounts then due plus a reasonable attorney fee. ORS 656.262(10); 656.382. Here, the employer refused to pay to claimant the temporary disability benefits awarded by the November 27, 1987 Determination Order. No explanation was offered for the refusal other than the fact that the employer did not believe claimant was substantively entitled to the award. As previously noted, the statute and administrative rules require payment of an award despite an appeal of that award. We conclude that assessment of a 25 percent penalty and associated attorney fee is appropriate.

Extent of Permanent Disability

The November 27, 1987 Determination Order awarded no unscheduled permanent disability. The Referee found that claimant had suffered a "very mild" permanent impairment as a result of the compensable injury and awarded 5 percent unscheduled permanent disability. Because we are not persuaded that claimant has suffered any permanent impairment as a result of the injury, we reinstate the Determination Order.

Dr. Mertens reported in August 1986 that claimant had no back impairment. More than one year later, Dr. Buza also reported an absence of any objective findings. He believed that claimant could return to work without restrictions. Similarly, Dr. Langston reported in November 1987 that claimant's examination was entirely

normal, with no objective evidence of injury or impairment. Like Dr. Mertens and Dr. Buza, he opined that claimant could return to work without limitations. We are persuaded by this testimony. We are unable to find that claimant has experienced any permanent impairment as a result of his compensable injury. Accordingly, we conclude that claimant has failed to establish entitlement to an award of permanent partial disability.

ORDER

The Referee's order dated February 2, 1988, as amended February 9, 1988, is reversed. The Referee's permanent partial disability award is reversed. The Determination Order which did not award any permanent disability is reinstated and affirmed. The self-insured employer's September 10, 1987 medical services denial is reinstated and upheld. In lieu of the Referee's award of interim compensation, the employer is ordered to pay temporary disability benefits for the period from July 28, 1986 through September 10, 1987, less amounts previously paid. Claimant's attorney is awarded 25 percent of the increased compensation payable pursuant to this order, not to exceed $3800. After making such payments, the employer is allowed to offset payments made for the period August 8, 1986 through September 10, 1987 against future permanent disability awards on this claim, if any. In addition, the employer shall pay claimant a penalty equal to 25 percent of the temporary disability benefits awarded by the November 27, 1987 Determination Order, less amounts previously paid. Regarding the penalty issue, claimant's attorney is awarded a reasonable fee of $400, to be paid by the employer.

CINDI A. CADIEUX, Claimant — WCB 86-16187
Becker, Hunt & Hess, Claimant's Attorneys — December 8, 1989
Roberts, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Ebner's order that: (1) upheld the insurer's denial of her occupational disease claim for a right ankle condition; and (2) declined to assess a penalty and associated attorney fee for alleged unreasonable failure to timely accept or deny her claim. Claimant contends on review that she is also entitled to an award of interim compensation and a penalty and associated attorney fee for the insurer's alleged unreasonable delay or refusal to pay interim compensation. We reverse on the compensability and untimely denial issues. We reject claimant's interim compensation contentions.

ISSUES

1. Compensability. Whether claimant's work activities for the employer were the major contributing cause of a worsening, or acceleration, of her preexisting, degenerative right ankle arthritis?

2. Penalty and Attorney Fee for Untimely Denial. Whether the insurer's failure to timely deny claimant's occupational disease claim was unreasonable?

3. Interim Compensation. Whether claimant timely raised the issue of alleged delay or failure to pay interim compensation?

FINDINGS OF FACT

Claimant, 35 years old as of the date of hearing, was employed primarily as a production line worker in a silicon wafer manufacturing plant from February 1980 until March 1987. Claimant is five feet, seven inches tall and weighed approximately 105 pounds while working for the employer.

In 1971, while in the military, claimant was involved in an automobile accident which resulted in a compound fracture of her right ankle. After approximately a one-year recovery period, claimant regained total use of her ankle. However, as a result of that injury, over a period of years claimant developed traumatic arthritis in her right ankle.

During her employment in the silicon wafer manufacturing plant, claimant worked in various departments with varying hours and duties. The employer initially operated 8-hour shifts. At this time, claimant worked in the wax mounting department. This job required a moderate amount of walking and lifting. In April 1982, claimant was transferred to the plate preparation department. The plate preparation department required significantly more lifting than had the wax mounting department. As a production worker in the plate preparation department, claimant was required to lift approximately 30 pounds and carry that weight from two to six feet. On average, this movement was repeated 120 times per work shift.

On October 1, 1982, claimant sought medical attention from the employer's nurse for right ankle swelling.

On November 3, 1983, pursuant to an examination by Dr. Howell, osteopath, claimant related a history of right ankle swelling and stiffness each summer. These symptoms did not interfere with her work or recreational activities.

In July 1984, the employer went to 12-hour shifts.

Commencing in late 1984, claimant began to experience increased pain and instability in her right ankle.

In January 1985, claimant again reported to the employer's nurse complaining of right ankle complaints.

In April 1985, claimant sought medical attention from Dr. Nelson, orthopedist. A reconstructive surgical procedure was recommended and was performed by Dr. Nelson on June 16, 1985. Claimant obtained insurance coverage for the resulting medical expenses through her health insurer.

In July 1985, the employer returned to 8-hour shifts.

Claimant was off work until December 1985. She returned to work for approximately one week and was then off work for approximately one month for an unrelated medical problem. She then returned to work in the wax mounting department in early 1986. She had few right ankle symptoms upon returning to work. However, after the first few months, her ankle became increasingly painful and finally disabling in September 1986. In November 1986, she had additional surgery performed on her ankle. She returned to work in March 1987 and was immediately discharged for absenteeism.

Claimant filed a claim for her right ankle condition with the employer on September 2, 1986. The insurer denied her claim 64 days later, on November 5, 1986.

The issue of interim compensation was neither raised or argued at hearing nor addressed in the Referee's order.

FINDINGS OF ULTIMATE FACT

Claimant's work activities for the employer were the major contributing cause of the acceleration of her degenerative right ankle arthritis to the extent that she required medical services and became disabled. The insurer's untimely denial of claimant's claim was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability

To establish compensability, claimant must prove that her work activities were the major contributing cause of a worsening of her right ankle arthritis resulting in an increase in pain to the extent that it caused disability or required medical services. Weller v. Union Carbide, 288 Or 27, 31 (1979).

Dr. Nelson opined on March 26, 1987 that claimant's work activities had aggravated her preexisting condition and accelerated the progression of her traumatic arthritis to the extent that she required additional surgery. The Referee rejected Dr. Nelson's opinion on the assumption that it was based upon an unreliable explanation by claimant of the lifting requirements of her job. In reaching this conclusion, the Referee cited inconsistencies between claimant's testimony and other evidence in the record.

We note preliminarily that, on review, the insurer contends that the Referee's "credibility" finding was based partly upon claimant's demeanor at hearing. Our review of the Referee's order refutes this contention. Our review discloses that the Referee's finding was based solely upon alleged inconsistencies in the record. When a referee's conclusion is based not on demeanor, but on an objective evaluation of the substance of a witness's testimony, the referee has no greater advantage in determining reliability than we do. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Claimant testified that she did not know she had arthritis in her ankle, that she did not avoid wearing high heeled shoes, and that she did not experience greater problems in either cold or hot weather. The Referee found that this testimony was inconsistent with other evidence. We disagree.

With regard to claimant's knowledge of the arthritic condition of her ankle, we find that the Referee misinterpreted the evidence. Claimant testified that she did not know she had an arthritic problem in her ankle until after commencing work with the employer. The record supports this testimony. The first post-1972 evidence in the record of any ankle problems appears in October 1982, more than a year and one-half after commencing work with the employer.

With regard to the high-heeled shoes issue, the

employer's nurse credibly testified that claimant complained of weakness in her right ankle which prohibited her from wearing high-heeled shoes. The Referee noted that claimant denied that she avoided wearing high-heeled shoes. However, it is again clear from the context of that denial that claimant was referring to the period of time prior to her employment, whereas the employer's nurse was referring to a comment made by claimant in March 1985.

Claimant testified that she had increased symptoms during warm weather. She denied having increased problems during cold weather. Claimant's testimony regarding increased symptoms during warm weather is supported by the fact that claimant informed Dr. Howell in November 1983 that she experienced increased symptoms in the summer months. While the employer's nurse credibly testified that claimant complained of increased symptoms due to cold weather in January 1985, we do not find this minor inconsistency sufficient grounds upon which to conclude that claimant is an unreliable historian with regard to other, more significant, questions.

Because claimant stated that lifting bothered her ankle even more than extending walking, the single, most significant question to be answered involves claimant's work activities, particularly her lifting activities . The Referee found that claimant testified to significantly greater lifting requirements than were testified to by two of her supervisors. We do not agree with the Referee's conclusion. Claimant testified to a moderate degree of lifting while employed in the wax mounting department. Upon review of the testimony of claimant's supervisors, we conclude that their understanding of claimant's lifting duties was not significantly different.

More importantly, claimant experienced a noticeable increase in symptoms in late 1984. At that time, claimant was working twelve-hour shifts in the plate preparation department. Claimant testified that she was required to lift 40 pounds approximately 130 times during each shift in this department. Claimant's supervisor Winn candidly testified that claimant was required to perform lifting activities "considerably more frequently" in the plate preparation department than in the wax mounting department. When asked to quantify the lifting requirements, he stated that workers in the plate preparation department were required to lift units weighing 30 pounds. In addition, he testified that there could be as many as 240 units to be moved during any shift. Because there were generally two workers in the department per shift, each worker would average approximately 120 units. Furthermore, he agreed that on some days claimant was probably working alone in the department.

Consequently, the discrepancy between claimant's testimony and that of her supervisors was not significant. Moreover, her supervisors admitted that they spent little time observing her work performance while she was in the plate preparation department.

As a result of the discrepancies that the Referee perceived to be present in claimant's testimony, the Referee found claimant to be unreliable. The Referee then assumed that the history claimant provided to Dr. Nelson might also be unreliable. The Referee concluded, therefore, that she was unable to find

Dr. Nelson's opinions persuasive. For the reasons stated above, we find no reason to question claimant's reliability as a historian. Moreover, we find no independent grounds upon which to reject Dr. Nelson's opinions. To the contrary, Dr. Nelson was claimant's treating physician for her ankle problems, and he had the advantage of having performed surgery on claimant's ankle in June 1985. We conclude that his opinions are entitled to considerable weight.

The insurer argues that Dr. Hopkins' opinions acknowledge that claimant's work activities may have increased claimant's symptoms, but that Dr. Hopkins persuasively opines that those activities were not the major cause of a worsening of her underlying condition leading to surgery. Our review of Dr. Hopkins' deposition testimony persuades us otherwise.

Dr. Hopkins repeatedly testified to the effect that claimant's work activities were not the major contributing cause of the onset of her arthritic condition. However, this is not the pertinent inquiry. Instead, the relevant issue is whether claimant's work activities were the major contributing cause of a worsening, or acceleration, of claimant's degenerative condition. On this question, Dr. Hopkins was equivocal. However, our review of Dr. Hopkins' testimony persuades us that he felt claimant's work activities with the employer <u>might</u> have resulted in an acceleration of her degenerative condition such that she was required to seek medical treatment sooner than she would have in the absence of those activities.

While Dr. Hopkins' testimony is expressed in terms of possibilities and, therefore, is not sufficient to sustain claimant's burden of proof, we find that when it is combined with Dr. Nelson's persuasive opinion, claimant has met her burden. We therefore conclude that claimant's current right ankle condition is compensable.

<u>Penalty and Attorney Fee for Untimely Denial</u>

The insurer conceded that its denial letter to claimant was untimely. The insurer offers no explanation for the delay. Instead, the insurer argues that the delay was <u>de minimus</u>, that claimant was not prejudiced by the delay, and that claimant herself filed her claim only after "considerable delay." None of these factors persuade us that the delay was not unreasonable. At most, they constitute mitigating factors in arriving at the amount of the penalty. However, to support a penalty, there must be an unpaid "amount then due" at the time of the denial. ORS 656.262(10); <u>Wacker Siltronic Corporation v. Satcher</u>, 91 Or App 654, 658 (1988). The record does not establish what, if any, amounts were "then due" as of the date of the insurer's denial. Accordingly, no penalty will be assessed. <u>See</u> ORS 656.262 (6); <u>Eastmoreland Hospital v. Reeves</u>, 94 Or App 698, 702 (1989).

Unlike a penalty, an attorney fee can be awarded even though there are no "amounts then due," if the insurer has otherwise unreasonably resisted the payment of compensation. <u>Ellis v. McCall Insulation</u>, 308 Or 74 (1989). We conclude that the insurer's untimely denial was an unreasonable resistance to the payment of compensation. A reasonable attorney fee will be assessed.

Interim Compensation

Claimant argues that the insurer failed to pay interim compensation prior to denial. The insurer argues that claimant failed to raise this as an issue at hearing and, therefore, should be precluded from doing so here. We agree. The issues at hearing were compensability and penalties and attorney fees for untimely denial. So far as the record discloses, entitlement to interim compensation was not raised at hearing. We conclude that claimant has waived entitlement to raise that issue on Board review. See Mavis v. SAIF, 45 Or App 1059 (1980).

ORDER

The Referee's order, dated January 15, 1988, is reversed. The insurer's denial dated November 5, 1986 is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded an assessed fee of $200 for prevailing on the untimely denial issue. In addition, with regard to the compensability issue, claimant's attorney is awarded an assessed fee of $2,000 for his services at hearing and $1,200 for his services on Board review. The Board approves a client-paid fee, not to exceed $1,128.

JAMES B. COPPLE, Claimant	WCB 86-06840
Stephen E. Lawrence, Claimant's Attorneys	December 8, 1989
Employers Defense Counsel, Defense Attorney	Order on Review

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of Referee Knudsen's order that set aside its compensability denial of claimant's head, neck, back, and lower extremities injury claim. On review, the issue is compensability.

The Board reverses the order of the Referee.

FINDINGS OF FACT

On March 14, 1986, claimant, a truck driver, was arrested for driving under the influence ("DUI") of alcohol. Attempting to avoid the breathalyzer test, he told the arresting officer that he was taking "back medicine." Because the insured had previously placed him on probation for incurring a traffic ticket, he knew that a DUI arrest would cost him his job.

A few days later, he inquired of a co-worker, Dennis Loffelmacher, about the relative benefits of the insured's disability plan and workers' compensation. On the afternoon of March 20, 1986, he called the attention of a security guard to a weak board on a catwalk adjacent to a sawdust bin. After loading his truck with sawdust, he returned later that evening. Shortly thereafter, the security guard found him lying face down in the bed of his truck -- a vertical distance of approximately 20 feet below the catwalk. The catwalk board, which he had earlier pointed out as weak, was broken.

Emergency medical technicians were called to the scene. Claimant was without any signs of cuts, scrapes, or broken bones. His initial verbal responses were disorganized. He was taken to a hospital emergency room.

Shortly thereafter, claimant filed a claim for a March 20, 1986 industrial injury to his head, neck, back, and lower extremities. The insurer denied his claim.

Claimant has no recollection of his alleged fall, other than hearing a cracking noise followed by a blow to the side of his head and shoulders.

Claimant did not sustain an accidental industrial injury on March 20, 1986.

CONCLUSIONS OF LAW

Apparently finding that claimant was a credible witness, the Referee concluded that he had proven compensability. We disagree.

Claimant must prove, by a preponderance of the evidence, that he sustained an accidental industrial injury on March 20, 1986. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). On this record, he has not done so.

The Referee seemed to conclude that claimant had proven compensability, because she found his "account of his memory of the accident" credible. Given the circumstances of this case, however, we do not view credibility as dispositive of the compensability issue. This is not a typical situation involving a worker's intact recollection. Rather, claimant has little recollection of the mechanics of his alleged fall. His testimony does little more than to describe circumstantial evidence of an accidental fall from the catwalk. To prove his case, claimant must rely on more than mere speculation.

Moreover, the Referee's credibility findings are equivocal. Accordingly, she stated:

> "During the hearing the claimant appeared slightly nervous and sometimes a little cocksure. His voice was frequently shrill and tense, but he was not evasive and admitted directly and without excuse to the driving under the influence charge. His manner was not prepossessing and he was not well groomed. Nonetheless, even the most unattractive claimant may be telling the truth. After careful thought, I find the claimant's account of his memory of the incident is credible.
>
> "I also find the claimant less than wholly credible regarding his understanding of what his employer's reaction would be when he discovered claimant was charged with drunken driving. That he anticipated the employer would 'be quite unhappy' is an understatement, but it is clear the claimant knew he would not be allowed to drive a truck. It is also clear that claimant was attempting to avoid being fired." (Emphasis added).

We profess confusion as to the Referee's credibility findings. After finding claimant's demeanor evasive, she goes on to find that he did not attempt to conceal his DUI arrest and that he was not well-groomed. Failing to conceal a commonly known and easily verifiable fact, such as a DUI arrest, is not a sign of credibility. Moreover, whether a claimant is well-groomed has nothing to do with assessing credibility. The Referee then proceeded to ironically find that claimant was not credible with respect to the effect of his DUI arrest on his security job. In sum, we are not persuaded by the Referee's equivocal credibility findings.

This is especially true in the light of claimant's conceded fabrication to the police during his DUI arrest. Claimant was, in fact, not taking "back medicine." His contrary statement to the arresting officer was an untruth. Accordingly, given the record before us on de novo review, we are not persuaded that claimant was a credible witness.

Turning to the mechanics of the alleged injury of March 20, 1986, we are persuaded by the well-reasoned and unrebutted expert testimony of Mr. Johnson, mechanical engineer. Johnson, who personally investigated the accident scene, testified that there were four possible accident scenarios: (1) falling through the catwalk Boards; (2) falling between the top and middle railings; (3) falling between the middle railing and the platform; and (4) falling over the top railing. He persuasively eliminated the first three scenarios. As to the last scenario, i.e., falling over the rail, Johnson did not rule it out. However, the physical evidence combined with claimant's testimony conflict with a finding that he fell over the rail. The top rail was 37' 3/4" above the platform. Claimant is 5' 10" tall. The top rail was, therefore, in excess of one-half of his height. Yet, the physical evidence reveals a broken platform board, which must necessarily have been caused by a downward, not an upward, force. In sum, the broken platform board is inconsistent with a finding that claimant fell up-and-over the top rail.

Likewise, claimant's testimony is not consistent with a finding that he fell over the rail. He testified that he heard a crack and then felt something hit his head and shoulders. While perhaps consistent with a scenario of falling downward through the catwalk boards, such testimony is not consistent with a scenario of toppling up and over the top 37' 3/4" rail.

On this record, claimant has not proven that it is more likely than not that he sustained an accidental industrial injury on March 20, 1986.

ORDER

The Referee's order, dated January 21, 1988, is reversed. The insurer's denial is reinstated and upheld. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $2,619.50.

PERCY J. GOULD, Claimant
Jeff Carter, Claimant's Attorney
Daryll E. Klein, Defense Attorney

WCB 87-04203
December 8, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of that portion of Referee Borchers' order, which awarded claimant 20 percent (38.4 degrees) scheduled permanent disability for binaural hearing loss, whereas a Determination Order awarded no permanent disability. On review, the issue is the extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

The opinion of Dr. Stoner, claimant's treating physician, was based solely on his examination of claimant. The worksheets submitted by claimant's attorney determining claimant's hearing loss at 20 percent were prepared by claimant's attorney. Stoner did not provide his opinion as to the percentage of claimant's hearing loss, nor did he include any worksheets to support his opinion that claimant suffered permanent binaural hearing loss.

Dr. Wilson and Dr. Mettler performed audiograms on claimant, in 1985 and 1987, respectively.

CONCLUSIONS OF LAW

The Referee awarded claimant 20 percent scheduled permanent disability for binaural hearing loss. We disagree.

The question in this case is whether claimant has met his burden of proof by establishing by a preponderance of the evidence that he suffered permanent impairment. We conclude that claimant has failed to meet his burden of proof.

The medical evidence on claimant's hearing loss is inconsistent. We generally assign greater weight to the opinion of claimant's treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are persuasive reasons to find Dr. Stoner's opinion not persuasive.

Although Dr. Stoner stated that claimant's hearing loss was work related, he failed to submit calculations which prove the amount of such loss. Claimant's attorney, not Stoner, completed the 1959 and 1987 hearing loss worksheets. Thus, Stoner never determined that claimant's hearing loss was 20 percent. Therefore, there is no persuasive expert medical evidence establishing the amount of claimant's hearing loss.

Two doctors, Dr. Wilson and Dr. Mettler, agree that claimant suffers no hearing loss, when claimant's prior hearing loss is considered. It is appropriate to consider such prior hearing loss, when determining the extent of a worker's scheduled disability in hearing loss cases. Theodore L. Nomeland, 41 Van Natta 2281 (issued this date). When there is a dispute between medical experts, we give more weight to those medical opinions

which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). See Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

Both Dr. Wilson and Dr. Mettler provided worksheets and well-reasoned explanations for their determinations that claimant suffers no permanent hearing loss due to the compensable condition. Furthermore, Dr. Mettler based his opinion on prior tests, his tests and an evaluation of claimant's testimony.

We find that only Wilson's and Mettler's opinions meet the Somers criteria and accordingly give their opinions more weight. We give little weight to Dr. Stoner's opinion, because he did not provide worksheets, nor did he personally determine any percentage of impairment. In view of the fact that the only medical evidence to rate impairment in this case indicates no impairment, we reverse the award of 20 percent.

ORDER

The Referee's order dated May 23, 1988, is reversed. The Determination Order dated April 28, 1986, is affirmed in all respects. A client-paid fee, not to exceed $328, is approved.

VICTOR F. LAMBERT, Claimant
Bottini, et al., Claimant's Attorneys
Davis, et al., Defense Attorneys

WCB 87-04603
December 8, 1989
Order on Review

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of his claim for right shoulder conditions. Claimant argued at hearing that his conditions were compensable either as an industrial injury or as an occupational disease. Claimant's brief on review was not timely submitted and, therefore, was not considered. The insurer elected not to file a respondent's brief. The issue on review is compensability of claimant's right shoulder conditions. We reverse.

FINDINGS OF FACT

Claimant began working as an assembler for the employer on August 20, 1986. Claimant's job duties involved the assembly of airplane "flap traps" using a variety of hand and power tools. He spent approximately one-third to one-half of his eight-hour work shift hammering. He spent approximately two hours per day using a torque wrench. Claimant is right-hand dominant.

In October 1986, claimant experienced the gradual onset of right shoulder pain. He had not had right shoulder complaints prior to his work for the employer.

Claimant was examined at the Kaiser Permanente Department of Industrial Medicine on October 17, 1986. Dr. Wiest diagnosed right infraspinous tendinitis and prescribed naprosyn medication. Claimant subsequently came under the care of Dr. Anderson.

On February 2, 1987, claimant was forced to quit work because of pain and catching in his right shoulder.

An arthrogram was subsequently performed which revealed

evidence of a rotator cuff tear. Cortisone injections provided a couple of weeks relief of symptoms; however, the symptoms then returned. Dr. Anderson referred claimant to Dr. Wilson, M.D.

Dr. Wilson examined claimant on February 24, 1987. He diagnosed degenerative tendinitis of the right shoulder as well as a rotator cuff tear. He proposed further conservative care.

On March 11, 1987, the insurer denied claimant's rotator cuff tear or degenerative tendinitis on the basis that the conditions were not related to claimant's employment.

On March 23, 1987, Dr. Wilson reported that surgical treatment in the form of acromionectomy and attempted rotator cuff repair was indicated. However, claimant wished to continue with conservative treatment.

On May 8, 1987, Dr. Langston, orthopedic surgeon, performed an independent medical examination of claimant. In addition to degenerative tendinitis and rotator cuff defect, Dr. Langston diagnosed an impingement syndrome, in which there is contact with the overlying bony and ligamentous arch when the arm is elevated.

Claimant was examined by Dr. Koski, an orthopedic surgeon with Kaiser Permanente, on August 14, 1987. Dr. Koski confirmed the diagnoses of Dr. Langston. On August 17, claimant was admitted to the hospital for surgery to be performed by Dr. Koski. That surgery included rotator cuff repair, anterior acromioplasty, and resection of the distal clavicle. Dr. Koski's operative report indicated that claimant's rotator cuff problem was a chronic condition.

FINDINGS OF ULTIMATE FACT

Claimant has three separable right shoulder conditions: rotator cuff tear; an impingement syndrome; and degenerative joint disease of the acromioclavicular joint. All three conditions preexisted his employment. We are unable to find that claimant's work activities were the major contributing cause of a worsening of claimant's impingement syndrome. We do find that claimant's work activities were the major cause of a worsening of his rotator cuff tear and degenerative joint disease.

CONCLUSIONS OF LAW AND OPINION

Claimant's claim is for a right shoulder condition. Neither the parties at hearing, nor the Referee, effectively deal with the fact that claimant's right shoulder "condition" is actually three separate conditions. However, because the medical evidence clearly establishes the existence of three separate conditions, all requiring surgery, we will address those conditions separately. Before proceeding, we must first determine upon what theory claimant's claim is properly based. At hearing, claimant contended that he has proven the compensability of his right shoulder "condition" whether analyzed as an occupational disease or an industrial injury. The Referee concluded that the claim is properly analyzed as an occupational disease. We agree.

An occupational disease is distinguishable from an injury in that a disease does not arise unexpectedly and is gradual rather than sudden in onset. James v. SAIF, 290 Or 343,(1981). The record

here establishes that claimant's condition was gradual in onset. The record is uncontroverted in this regard. Moreover, given the nature of claimant's work activities, claimant's right shoulder complaints were not unlikely to follow from the repetitive stress placed upon his shoulder. We conclude that the Referee properly analyzed claimant's claim as an occupational disease.

To prevail on an occupational disease theory, claimant must establish by a preponderance of the evidence that his work exposures were the major contributing cause of the onset of his condition, or the worsening of that condition if it preexisted his employment. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985). We must, therefore, first determine whether the denied conditions preexisted claimant's employment.

Dr. Koski opined that it was probable that claimant's impingement syndrome and degenerative joint disease preexisted his employment. In addition, he noted in his surgical report that the torn rotator cuff appeared to be a chronic condition. Dr. Langston also opined that claimant's rotator cuff tear was the result of degenerative processes preexisting his employment. Dr. Wilson expressed no opinion as to whether any of the conditions preexisted claimant's employment. In the absence of any evidence to the contrary, we conclude that all three conditions preexisted claimant's employment, although they were asymptomatic.

We next examine the record to determine whether claimant's work place exposures were the major contributing cause of a pathological worsening of any of the conditions. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983). As of the date of Dr. Wilson's April 27, 1987 report, claimant's impingement syndrome had not yet been diagnosed. Consequently, Dr. Wilson's report does not support claimant's claim to the extent it involves right shoulder impingement syndrome. Similarly, Dr. Langston expressed no opinion regarding the work-relatedness of the impingement syndrome. Finally, Dr. Koski reported only a "possible" work contribution to the impingement syndrome. Claimant must prove more than a mere possibility that his work caused a worsening. Paige v. SAIF, 75 Or App 160, 163 (1985). We conclude that claimant has failed to prove the compensability of his right shoulder impingement syndrome.

We turn next to claimant's rotator cuff tear and his degenerative tendinitis conditions. Dr. Wilson spoke to both of these conditions in his April 27, 1987 report to claimant's attorney. In that letter, Dr. Wilson stated:

> "[I]n light of my review of [claimant's] work site and job duties it would be my impression that use of a heavy maul and pounding motions above shoulder level could have contributed to his present condition. In answer to [a question posed by claimant's attorney], it would be my opinion that [claimant's] employment is a major contributing cause to his right shoulder condition and need for surgery."

The Referee concluded that Dr. Wilson's opinion contained conflicting information and presented a "bare conclusion." We do not agree. We find that Dr. Wilson's

ultimate conclusion regarding work-relatedness is contained in his final statement to the effect that claimant's employment was a major contributing cause of his condition requiring treatment. Dr. Wilson's previous statement that his work activities "could" have contributed to his condition is not conflicting; instead, we are persuaded that the statement was made merely in response to a question to that effect from claimant's counsel. Moreover, Dr. Wilson explained his opinion on the basis of a lack of evidence of off-work activities that might have contributed to claimant's condition, as well as a review of claimant's job site and job duties. We conclude that Dr. Wilson's report is both internally consistent and supported by reasoning.

Dr. Koski opined that it was "possible" that claimant's work exposure could have contributed to the rotator cuff tear. Dr. Koski offers no opinion with regard to the contribution of claimant's work exposure to a worsening of his degenerative condition. Standing alone, Dr. Koski's opinion would be clearly insufficient to establish claimant's claim. However, when read in conjunction with Dr. Wilson's opinion, we find that Dr. Koski's acknowledgment of a possible connection renders some modicum of support to the compensability of claimant's rotator cuff tear.

Dr. Langston addresses the work-relatedness of only the rotator cuff tear. Dr. Langston opines in this regard:

> "The rotator cuff defect, which was diagnosed, could easily be due to degenerative activity and would be present prior to the work activities he describes. However, with the work activity he could be made temporarily symptomatic, particularly if the defect was present prior to beginning his work activity. This made him symptomatic, particularly with working at elevations above shoulder height. The surgery recommended by Dr. Wilson could improve his symptoms, however, with the degenerative disease of the rotator cuff."

As noted by the Referee, Dr. Langston's report does no more than support a symptomatic worsening as a result of claimant's work activities. However, we are more persuaded by the opinions of claimant's treating physician, Dr. Wilson, and the physician who performed his surgery, Dr. Koski, than we are persuaded by Dr. Langston who examined claimant only once seven months following onset of claimant's symptoms.

We conclude that claimant has failed to establish the compensability of his right shoulder impingement syndrome. However, he has proven the compensability of his torn rotator cuff and his degenerative tendinitis conditions.

Although claimant has prevailed on Board review over an insurer denial of his claim for compensation, no attorney fee will be awarded. We cannot award an "assessed fee" unless claimant's counsel has filed a statement of services. See OAR 438-15-005(2); 438-15-010(5). These rules are effective January 1, 1988 and apply to all cases pending before the Board on that date. See OAR 438-05-010; 438-15-003(2). Inasmuch as no statement of services has been received, an assessed fee will not be awarded.

ORDER

The Referee's order, dated November 27, 1987, is reversed. The insurer's denial, dated March 11, 1987, is set aside. Claimant's torn rotator cuff and degenerative tendinitis claims are remanded to the insurer for acceptance and processing according to law. The insurer is not responsible for treatment or disability relating to claimant's right shoulder impingement syndrome.

EDWARD D. LUCAS, Claimant	WCB 85-08631
Malagon & Moore, Claimant's Attorneys	December 8, 1989
Charles Lisle (SAIF), Defense Attorney	Order on Remand

Reviewed by Board Members Nichols, Brittingham and Crider.

This matter is before the Board on remand from the Court of Appeals. Lucas v. Clark, 91 Or App 522 (1988). We have been instructed to reconsider this case in light of the decisions in Armstrong v. Asten-Hill Co., 90 Or App 200 (1988), Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988), and International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988). Pending our review on remand, the Supreme Court issued its decision in Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989), in which it clarified its holding in Gwynn, supra. Accordingly, we also reconsider our former order in light of the decision in Perry.

Claimant requests review of that portion of Referee Mongrain's order that upheld the SAIF Corporation's denial of his aggravation claim for a mid back, low back and bilateral leg condition. The sole issue on review is compensability of claimant's aggravation claim. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable back and bilateral leg injury in April 1977. At that time, he was working as a choker setter for SAIF's insured. Following his injury, claimant experienced mid and low back pain, along with weakness and spasticity in both legs. Diagnostic studies of claimant's lumbar spine were interpreted as essentially normal. However, the injury resulted in herniated discs in his dorsal spine at D-9 and D-10. Claimant underwent a decompressive thoracic laminectomy and spleenectomy in 1977.

Claimant's injury claim was initially closed by Determination Order, issued March 4, 1980. At that time, claimant received an award of 50 percent unscheduled permanent disability for his back, 30 percent scheduled permanent disability for his right leg, and 15 percent scheduled disability for his left leg. The claim was reopened several months later when claimant experienced increased mid and low back pain, along with bulging of the right anterior chest wall. He was diagnosed with a protruded disc at T-9, which was surgically repaired in July 1980.

The claim was reclosed by an April 1981 Determination Order awarding temporary disability compensation from June 19, 1980 through March 30, 1981, and no additional permanent disability. At an examination in late March 1981, claimant had demonstrated severe spastic paraparesis of both lower extremities,

moderately hyperactive knee and ankle reflexes with severe clonus on the right, and severely hyperactive knee and ankle reflexes on the left.

An Opinion and Order, issued April 2, 1982, increased claimant's right leg scheduled disability award to 50 percent. At that time, claimant was restricted to light and sedentary activity. He could not run or jump, and he could only walk limited distances.

Claimant experienced additional symptomatic flare-ups in November 1982, March 1983, November 1983 and April 1984. Documented back symptoms at the time of these exacerbations included increased mid and low back pain, with 50 percent loss in range of motion in the back. Documented leg symptoms included: marked spastic paresis and pain in both legs; right leg numbness and tingling, with grossly impaired motion rates, severely hyperactive knee and ankle reflexes, and clonus; and moderately impaired motion rates on the left, with severely hyperactive knee reflexes, moderately hyperactive ankle reflexes, and clonus. Prolonged sitting, standing, walking, bending or lifting aggravated claimant's back and leg symptoms. The exacerbations in March 1983, November 1983 and April 1984 resulted in periods of total disability of at least 60 days.

A Stipulated Order, approved August 23, 1984, increased claimant's right leg disability award to 60 percent. The Stipulated Order did not provide any additional disability award for claimant's back or left leg. At the time of the Stipulated Order, claimant continued to be limited to light and sedentary work. He had successfully worked in a light duty position as a janitor, and he had engaged in some light duty self-employment endeavors, including small engine repair work. Claimant's treatment prior to the Stipulated Order included the aforementioned dorsal spine surgery, physical therapy, range of motion exercises, pain medication, Valium and muscle relaxants.

Claimant experienced yet another symptomatic exacerbation in January 1985. The aggravation claim now before us on review is based on this exacerbation. Documented symptoms in early 1985 included increased mid and low back pain; numbness and tingling in the right leg aggravated by prolonged sitting; moderately severe spastic paresis in both legs; and moderately hyperactive knee and ankle reflexes with clonus.

Claimant sought treatment from Dr. Hulce, M.D., who prescribed physical therapy, ultrasound treatment, motivation exercises and medication. Dr. Saez, neurosurgeon, began treating claimant in March 1985, on referral from Dr. Hulce. Diagnostic studies in April 1985 revealed no new changes in the thoracic spine, but did document a herniated disc in the lumbar spine at L4-5. Dr. Saez prescribed physical therapy, traction, ultrasound, range of motion exercises and medication.

Claimant filed a claim for aggravation of his 1977 injury, based on his herniated lumbar disc and increased back and leg symptoms. SAIF issued a denial of the claim on May 8, 1985, and claimant requested a hearing.

FINDINGS OF ULTIMATE FACT

The herniated lumbar disc diagnosed in April 1985 was not causally related to claimant's 1977 injury.

Claimant's alleged aggravation in 1985 resulted in a symptomatic exacerbation, rather than a pathological exacerbation, of his mid back condition. That mid back exacerbation rendered him less able to work than at the time of the August 1984 Stipulated Order. That stipulation contemplated future periods of waxing and waning mid back symptoms resulting in periods of temporary total disability. The additional diminished earning capacity claimant experienced as a result of the mid back exacerbation did not exceed that contemplated by the August 1984 Stipulated Order in either degree or duration. Claimant's mid back exacerbation in 1985 did not result in total disability for more than 14 consecutive days.

The August 1984 Stipulated Order contemplated future periods of waxing and waning leg symptoms resulting in diminished use or function. The increased bilateral leg symptoms claimant experienced in 1985 did not result in greater loss in use or function than contemplated by the August 1984 Stipulated Order.

CONCLUSIONS AND OPINION

We agree with the Referee's ultimate conclusion that claimant has not demonstrated a compensable aggravation of his 1977 injury. However, we use a different analysis in reaching that conclusion.

Claimant can establish an aggravation based on either his unscheduled mid and low back conditions, or his scheduled bilateral leg condition. We use a somewhat different analysis in reviewing aggravation claims based on worsening of unscheduled, as opposed to scheduled, body parts. The former is based on a symptomatic or pathological exacerbation resulting in diminished earning capacity, whereas the latter is predicated on an exacerbation resulting in reduced loss of use or function. Consistent with this distinction, we discuss claimant's back and leg conditions separately.

Aggravation of Back Condition

As a general rule, in an unscheduled disability case a claimant is entitled to have his claim reopened under ORS 656.273 when, as a result of either a pathological worsening or a symptomatic worsening of his compensable condition, he is less able to work than at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). The worsening may be either temporary or permanent.

We write to discuss our understanding of the effect of Gwynn v. SAIF, supra, and Perry v. SAIF, supra, on the Smith analysis.

Assuming the claimant's aggravation rights continued under ORS 656.273(4), the first inquiry is whether, as a factual matter, the injured worker's physical condition or symptoms became exacerbated. If not, the inquiry is ended. The worker will not have established facts essential to a showing of a "worsened condition" under ORS 656.273(1). If the injured worker did experience an exacerbation, whether or not anticipated, the analysis continues.

The second inquiry is whether, as a result of the exacerbation, the claimant suffered a diminished earning

capacity. Not every exacerbation of a physical condition or symptoms results in a diminished earning capacity. Whether claimant suffered a diminished earning capacity is a question of fact. Perry v. SAIF, supra. If the claimant's earning capacity was diminished, even temporarily, below the level fixed at the time of the last award or arrangement of compensation, the worker's condition will generally have worsened and he or she will be entitled to additional compensation under ORS 656.273(1). Smith v. SAIF, supra.

In some cases, however, the last award or arrangement of unscheduled permanent partial disability compensation will have been predicated on anticipated future exacerbations of the claimant's condition or symptoms to the extent of temporarily diminishing his earning capacity. In such cases, the appropriate additional inquiry is whether the degree or duration of the claimant's reduced earning capacity is greater than was anticipated by the last award or arrangement of unscheduled permanent partial disability compensation. If so, the claimant has suffered an aggravation. Smith v. SAIF, supra. If not, or if it cannot be determined from the last award or arrangement what duration or degree of reduced earning capacity was anticipated, then the inquiry becomes whether the claimant experienced 14 consecutive days of total disability (incapacity from regularly performing work at a gainful and suitable occupation) or inpatient hospitalization. In those cases in which he has, the claimant will be deemed to have suffered a worsened condition for purposes of ORS 656.273(1). Gwynn v. SAIF, 304 Or 345 (1987).

In summary, for every claim of aggravation of an unscheduled condition, the claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity. In those cases in which the last award or arrangement of unscheduled permanent partial disability compensation anticipated future periods of increased symptoms or exacerbation of the physical condition, accompanied by a diminished earning capacity, the claimant must also prove that his earning capacity was diminished longer or in greater degree than was anticipated or that his earning capacity was diminished to the extent of total disability, and resulted in 14 consecutive days of total disability or inpatient hospitalization.

We apply this analysis to the facts of the present case. We first consider claimant's low back condition, as distinct from his thoracic spine injury. The medical record indicates that claimant's increased low back symptoms in 1985 were attributable to a herniated lumbar disc. The Referee apparently concluded that claimant's 1977 compensable injury did not materially contribute to the herniated lumbar disc. We agree. Dr. Saez, claimant's treating neurosurgeon, opined that claimant's herniated disc was not related to the 1977 injury. The record contains no persuasive evidence to the contrary. Accordingly, we do not consider claimant's low back condition in determining whether he has sustained an aggravation of his 1977 injury.

Claimant must, instead, demonstrate that he sustained a compensable aggravation of his separate mid back condition. In that regard, we apply the five-step analysis discussed above.

Step 1: Did claimant experience a pathological or symptomatic exacerbation of his mid back condition?

Claimant's last arrangement of compensation was the

August 1984 Stipulated Order. The record contains no evidence of a pathological worsening of claimant's thoracic spine after the Stipulated Order. However, we are persuaded that claimant sustained a symptomatic exacerbation of his mid back condition.

Claimant testified that his mid back symptoms became more intense and covered a wider area of his mid back in January 1985. That testimony is consistent with the reports of Dr. Campagna, neurosurgeon, who treated claimant from November 1982 through 1984, and Dr. Saez, who has been claimant's treating neurosurgeon since March 1985. Both doctors noted claimant's complaints of increased symptoms, and they agreed that claimant had sustained a symptomatic exacerbation of his 1977 injury. Based on their opinion and claimant's testimony, we find that claimant sustained a symptomatic exacerbation of his mid back condition.

Step 2: Did claimant's symptomatic exacerbation result in diminished earning capacity below the level fixed at the time of the last arrangement of compensation?

At the time of the August 1984 Stipulated Order, claimant was capable of performing light and sedentary work. By comparison, the record indicates that claimant was totally disabled at the time of his alleged aggravation. In February 1985, treating physician Hulce opined that claimant was "temporarily disabled." In August 1986, treating neurosurgeon Saez opined that claimant's increased symptoms in early 1985 "rendered him unable to work at that time." Claimant testified that, at the time of his alleged aggravation, he was no longer able to control his symptoms by frequent changes in his position. There is no evidence that claimant was not totally disabled in early 1985. Accordingly, we conclude that claimant's symptomatic exacerbation resulted in diminished earning capacity below the level fixed at the time of the August 1984 Stipulated Order.

Step 3: Did the last arrangement of compensation contemplate future periods of increased symptoms accompanied by a diminished earning capacity?

In the absence of an indication to the contrary, we assume that, at the time the parties entered into the August 1984 Stipulated Order, they considered any existing evidence that claimant would have periodic symptomatic flare-ups of his mid back condition that would render him unable to perform light or sedentary work. Gwynn v. SAIF, 91 Or App 84, 88 (1988).

The record contains medical reports documenting symptomatic mid back flare-ups in November 1982, March 1983, November 1983 and April 1984. The latter three exacerbations resulted in periods of total disability. There is nothing in the record to indicate that the parties did not consider medical documentation of these flare-ups when they entered into the August 1984 Stipulated Order. Furthermore, in light of these prior exacerbations, future disabling mid back flare-ups were anticipated. Accordingly, we conclude that the August 1984 Stipulated Order contemplated future periods of increased mid back symptoms accompanied by diminished earning capacity.

Step 4: Did claimant's diminished earning capacity from his exacerbation exceed that anticipated by the last

arrangement of compensation, in terms of either degree or duration?

As discussed above, we are persuaded that the August 1984 Stipulated Order contemplated that claimant would continue to be subject to symptomatic mid back exacerbations of the type he had experienced in the past. There is nothing in the record to persuade us that claimant's current mid back exacerbation was greater in degree than the mid back pain he had experienced at the time of his prior exacerbations. In particular, we note that claimant's mid back exacerbation did not result in treatment different from what he had received for his prior exacerbations.

Furthermore, we are not persuaded that the period of total disability resulting from the current mid back exacerbation was longer in duration than the disability associated with the prior flare-ups. At the time of each of these prior exacerbations, treating neurosurgeon Campagna considered claimant disabled for periods of at least 60 days. Dr. Saez opined in April 1986 that claimant's current exacerbation in the "early months of 1985 . . . rendered him unable to work at that time." It is not clear from this general statement how long claimant was totally disabled. Moreover, some portion of claimant's disabling symptoms prior to that date were attributable to his noncompensable low back condition.

In light of this evidence, we conclude that claimant has not demonstrated that his mid back exacerbation in 1985 was greater in degree or duration than the exacerbations anticipated by the August 1984 Stipulated Order.

Step 5: Did claimant's exacerbation result in 14 days of total disability or inpatient hospitalization?

Dr. Saez opined that claimant's exacerbation in early 1985 rendered him unable to work. However, as discussed above, we are unable to discern to what degree claimant's disabling symptoms at that time were attributable to his noncompensable low back condition. Given that fact, we are not persuaded that claimant's mid back exacerbation, standing alone, resulted in a period of total disability exceeding 14 days.

Accordingly, we conclude that claimant has not carried his burden of proving that his mid back exacerbation resulted in a compensable aggravation of his 1977 injury.

Aggravation of Bilateral Leg Condition

In order to demonstrate a compensable aggravation of his bilateral leg condition, claimant must demonstrate that he has experienced increased loss of use or function of his legs since the August 1984 Stipulated Order. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988). The increased loss of use or function must be greater than any future periods of increased disability, that is, increased loss of use or function, contemplated by the last arrangement of compensation. Id.

Here, the August 1985 Stipulated Order awarded an additional 10 percent scheduled permanent disability for claimant's right leg. Prior to that order, claimant experienced symptomatic exacerbations in March 1983, November 1983 and April

1984. Medical reports at the time of these exacerbations make repeated reference to severe bilateral leg symptoms. There is nothing in the record to indicate that the parties did not consider this evidence in entering into the August 1984 Stipulated Order.

On this record, we conclude that the Stipulated Order contemplated future flare-ups of bilateral leg symptoms of the type claimant experienced in 1983 and 1984. We further conclude that claimant's current exacerbation resulted in the same type of moderately severe leg symptoms he experienced at the time of his prior exacerbations. Moreover, we are unable to discern to what degree claimant's disability following his current exacerbation was related to his leg condition, as distinct from his noncompensable low back condition. Accordingly, we are not persuaded that the duration of claimant's diminished leg use or function exceeded that associated with his prior exacerbations. Consequently, we conclude that claimant has not demonstrated a compensable aggravation based on his bilateral leg condition.

ORDER

The Referee's order, dated December 2, 1986, is affirmed.

Board Member Crider, dissenting:

I agree with the general analysis adopted by the majority regarding aggravation of unscheduled and scheduled injuries. However, I disagree with the majority's application of this analysis to the facts of this case.

Like the majority, I am persuaded that claimant sustained a symptomatic exacerbation of his mid back condition, and that this exacerbation resulted in diminished earning capacity. My disagreement is with the majority's analysis at Step 3. I am not persuaded that future mid back flare-ups, accompanied by diminished earning capacity, were considered by the August 1984 Stipulated Order.

The court as fact finder in Gwynn v. SAIF, 91 Or App 84 (1988), was willing to assume that a stipulated award contemplated future disabling flare-ups simply because there was evidence available to the parties suggesting that such would occur. Nevertheless, the court did not require that we, as fact finder, indulge in this assumption in every case that comes before us. To do so routinely is effectively to ignore the Supreme Court's instructions in Gwynn v. SAIF, 304 Or 345 (1987). In that case, the Court held that it was error to find that waxing and waning was taken into account in reaching an agreement that produced a particular award because it was "knowable that the claimant will experience a waxing and waning of symptoms . . ." at the time of the stipulation. The appropriate question, according to the Court, is whether an award was predicated on an expectation of future disabling flare-ups.

In this case, we cannot assume that flare-ups were contemplated by the August 1984 Stipulated Order. Claimant's 50 percent unscheduled disability was awarded by Determination Order issued March 4, 1980. The reported periods of total disability relied on by the majority occured after this Determination Order and prior to the 1984 Stipulated Order. Nevertheless, the Stipulated Order awarded no additional unscheduled disability.

Thus, any presumption that future exacerbations were taken into account has been rebutted.

Moreover, the medical reports associated with these prior periods indicate that claimant is suffering chronic back pain and leg spasticity, numbness and radiating pain. The record does not indicate that claimant's condition was worse during the periods of reported total disability than at other times; nor does any doctor predict future disabling flare-ups.

On this record, I am not persuaded that the August 1984 Stipulated Order anticipated future disabling exacerbations of claimant's mid back condition. Given that fact, there is no need to proceed further in the analysis. Claimant has demonstrated that his increased mid back symptoms were a compensable aggravation of his 1977 injury claim. Accordingly, I would reverse the Referee on this issue and remand the claim to SAIF for further processing.

WANDA J. MILLER, Claimant — WCB 87-17228
Brothers, et al., Claimant's Attorneys — December 8, 1989
Richard Barber, Jr. (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Michael Johnson's order that set aside the SAIF Corporation's denial of her aggravation claim for a low back injury but declined to award additional temporary disability benefits on the basis that claimant had withdrawn from the work force. See Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). The sole issue on review is entitlement to temporary disability benefits. We reverse.

FINDINGS OF FACT

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

Claimant was not actively seeking work at the time of her aggravation because her worsened low back symptoms precluded a successful return to work.

Claimant had not retired from the work force at the time of her aggravation.

CONCLUSIONS OF LAW AND OPINION

Relying upon Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), the Referee concluded that claimant was not entitled to temporary total disability (TTD) benefits. The Referee reasoned that claimant was not a part of the work force at the time the aggravation occurred. The Referee stated that Cutright and its progeny forbid payment of temporary disability compensation to a worker in claimant's position. We do not agree that Cutright is applicable here. Therefore, we reverse.

The facts here are not in dispute. Claimant credibly testified that she intended to return to work approximately one year after leaving work to have her baby. Financial considerations would not allow her to remain at home longer. She left work in May 1986. In approximately March 1987, she commenced an exercise program designed, in part, to facilitate her return to the work

force. In May 1987, she and her husband discussed her return to work within a month or two. However, a worsening of her symptoms which had commenced in March 1987 progressed to the point that she was unable to return to the work force. Her treating physician subsequently took her off work retroactive to June 22, 1987. SAIF does not contest the Referee's finding that claimant suffered a compensable aggravation as of that date.

Following issuance of the Referee's order, the Court of Appeals decided Chapel of Memories v. Davis, 91 Or App 232 (1988). The issue in Davis, as here, was whether claimant had withdrawn from the work force at the time of a compensable aggravation such that he was not entitled to recovery of TTD benefits. The court concluded that claimant had not withdrawn from the work force. The court noted that claimant was not actively seeking work at the time of the aggravation because his worsened symptoms rendered him unable to seek employment. The court also noted that claimant had credibly testified that he was not retired and that he would accept a job within his physical limitations.

The facts which support a finding that claimant has not withdrawn from the work force are even stronger than they were in Davis. Claimant in Davis was 63 years old. Claimant here was 27 years old as of the date of hearing. In addition, claimant here was actively engaged in an exercise program to prepare for reentry to the work force at the time that her symptoms began to worsen. Further, whereas claimant in Davis had applied for Social Security retirement benefits, claimant here investigated the possibility of an unemployment claim. Compare Sykes v. Weyerhaeuser Co., 90 Or App 41, 44 (1988) with Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987).

"A claimant who seeks to re-enter the work force after voluntary withdrawal, but is prevented from doing so by a compensable injury, may qualify as a worker although not presently engaged to furnish services for a remuneration." SAIF v. Stephens, 308 Or 41, 47 (1989). This is such a case. The reason claimant was not actively seeking employment was due to her worsened injury condition. She was willing to work and had made reasonable efforts to return to work.

In sum, we are persuaded that, if not for claimant's worsened condition, she would be an active member of the work force. Consequently, she has lost wages as a result of her compensable aggravation. She, therefore, is entitled to temporary disability compensation from the date of her aggravation.

ORDER

The Referee's order dated February 12, 1988 is affirmed in part and reversed in part. That portion of the Referee's order that set aside the SAIF Corporation's October 12, 1987 aggravation denial is affirmed. That portion of the Referee's order that declined to award additional temporary total disability compensation is reversed. The claim is remanded to SAIF for acceptance and processing in accordance with this opinion and applicable law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

THEODORE L. NOMELAND, Claimant
Charles Robinowitz, Claimant's Attorney
David Jorling, Defense Attorney

WCB 88-01084
December 8, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of that portion of Referee Tenenbaum's order which increased claimant's scheduled permanent disability award for binaural hearing loss from 16.16 percent (31.03 degrees), as awarded by Determination Order, to 56.16 percent (107.83 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

We note at the outset that the Oregon Self Insured Association has submitted an Amicus Brief and we have considered it on review.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Findings" section of the Referee's order.

CONCLUSIONS OF LAW

The Referee concluded that claimant's preexisting hearing loss should not be offset against his scheduled permanent disability award for binaural hearing loss. We disagree.

ORS 656.214(2) provides:

> "When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury."

In conjunction with this provision, ORS 656.214(2)(g) provides:

> "For partial or complete loss of hearing in both ears, that proportion of 192 degrees which the combined binaural hearing hearing loss bears to normal combined binaural hearing. For the purpose of this paragraph, combined binaural hearing loss shall be calculated by taking seven times the hearing loss in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount by eight. In the case of individuals with compensable hearing loss involving both ears, either the method of calculation for monaural hearing loss or that for binaural hearing loss shall be used, depending on which allow the greater award of disability."

Finally, former OAR 436-30-360(2) (renumbered 436-35-250(2)(a)(b)) provides:

> "Compensation for work-related hearing loss, whether diagnosed as an occupational disease or acoustic trauma, will be offset by

preexisting hearing loss if previously compensated, presbycusis, or if supporting evidence such as base-line or pre-exposure audiograms are provided."

The Referee concluded that claimant was entitled to permanent disability for his cumulative hearing loss even though the parties stipulated that there was documented hearing loss prior to claimant's work exposure. She reasoned that under Oregon law, offsets for prior impairment were not allowed unless the impairment had been previously compensated for in Oregon's workers' compensation system.

As noted above, ORS 656.214(2) provides for permanent disability compensation where there is permanent loss of use or function, due to the industrial injury. [Emphasis added]. It does not provide compensation for permanent disability unrelated to an industrial injury. Further, although former OAR 436-30-360(2) does allow an offset for previously compensated impairment, it also allows for an offset for preexisting hearing loss if there is supporting evidence such as base-line or pre-exposure audiograms. This is consistent with ORS 656.214(2).

Here, the parties stipulated that the March 1974 baseline was "pre-exposure" in that claimant would not have had any appreciable hearing loss in the first six months he worked for the employer. Further, the parties have stipulated that if a baseline were to be used, the March 1974 test would be an appropriate baseline to use. Finally, the March 1974 test was used by the Evaluation Division in arriving at the permanent disability awarded by the Determination Order.

We conclude that offsetting claimant's documented preexisting hearing loss in determining his scheduled permanent disability is appropriate. See former OAR 436-30-360(2). We further conclude that the Determination Order correctly offset the preexisting hearing loss and therefore should be reinstated.

ORDER

The Referee's order dated June 3, 1988, as amended June 13, 1989, is reversed. The July 31, 1987 Determination Order is reinstated and affirmed.

DEBORA THOMPSON, Claimant	WCB 88-07791
Black, et al., Claimant's Attorneys	December 8, 1989
James Dodge (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Nichols' order which declined to assess a penalty and attorney fee for an alleged unreasonable failure to pay a medical bill. The issue on review is a penalty and associated attorney fee. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusion" with the following comment.

The time within which to accept or deny a claim runs from the time the insurer or self-insured employer has notice or knowledge of the claim. ORS 656.262(6). Claimant has the burden of proving that SAIF failed to accept or deny a claim within 60 days of filing. Here, there is no direct evidence as to when the claim was filed, nor has claimant established when or if the medical provider's billing was directed and mailed to SAIF. Therefore, the presumption of receipt created by ORS 40.135 (1)(q) has not been raised.

ORDER

The Referee's order dated June 14, 1988 is affirmed.

TERESA L. WALKER, Claimant
Quintin B. Estell, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 87-16243
December 8, 1989
Order on Review

Reviewed by Board Members Howell, Perry and Speer.

Claimant requests review of Referee Huff's order that upheld the SAIF Corporation's "new injury" denial of her low back condition. The Referee concluded that SAIF properly processed the claim as an aggravation of a prior compensable injury. We affirm.

ISSUE

Whether claimant suffered an aggravation of her prior accepted condition or, instead, a new injury?

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee applied that form of the "last injurious exposure rule" which applies in a successive injury context where a compensable injury occurs during one employment and the question is whether a subsequent employment contributed to a worsening of such injury. See Boise Cascade v. Starbuck, 296 Or 238 (1984) and Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). We have previously held that where responsibility between employers/insurers is not at issue, the "last injurious exposure rule" does not apply. Jerry W. Sargent, 38 Van Natta 104 (1986).

Although the "last injurious exposure rule" is inapplicable to a determination of whether a worker suffered a "new injury" or aggravation, we noted in Sargent, supra, that the appropriate test involved a similar analysis. We did not state what that analysis was.

At this time we expressly adopt as the test for distinguishing an aggravation from a "new injury", where neither compensability or responsibility is in dispute, the following:

> Worsened symptoms of a compensable injury represent an aggravation, assuming all other requirements of an aggravation claim are met. A worker suffers a compensable new injury only if a subsequent incident or employment exposure independently

contributes to a worsening of the prior underlying condition.

With that clarification, we adopt the Referee's "Opinion" as our own.

ORDER

The Referee's order dated February 22, 1988 is affirmed.

ROBERT S. WATERSTON, Claimant
Merrill Schneider, Claimant's Attorney
Ann Kelley, Assistant Attorney General

WCB 87-02554
December 8, 1989
Order on Reconsideration

The Inmate Injury Fund (Fund) has requested reconsideration of the Board's Order On Review, issued November 8, 1989. In that order, we assessed a $500 penalty regarding the Fund's unreasonable premature closure of claimant's injury claim. On reconsideration, the Fund challenges the penalty on the grounds that: (1) the Board assessed $500, rather than a penalty based on a percentage of the amount due, as required by ORS 656.262(10); (2) there is nothing in the record to indicate that $500 is the appropriate penalty; and (3) no more than a 10 percent penalty is appropriate.

We are not persuaded by the Fund's argument. The penalty in issue was assessed under former ORS 656.268(3). That provision provides for a mandatory, minimum $500 fee where a carrier's claim closure is not supported by substantial evidence. In our November 8, 1989 Order on Review, we concluded that the Fund's closure was premature and not supported by substantial evidence. Consequently, we assessed the minimum $500 fee required under ORS 656.268(3).

Accordingly, our November 8, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 8, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

PAMELA E. ADAIR, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 89-0390M
December 11, 1989
Own Motion Order

The SAIF Corporation voluntarily reopened the above-entitled claim in March 1989 for a worsening of claimant's compensable right carpal tunnel condition. SAIF has now submitted an Insurer's Determination Request to the Compliance Section, and it has referred the claim to the Board for closure under our own motion authority. We conclude that we are without jurisdiction to close the claim under our own motion authority. The claim should, instead, be closed by the Evaluations Section pursuant to ORS 656.268.

Our own motion authority only extends to worsened conditions arising after the expiration of aggravation rights. According to an August 1986 Determination Order issued in the present claim, aggravation rights expired five years from February 4, 1984. Therefore, we cannot close this claim under our own motion authority unless claimant's worsening occurred after February 4, 1989. Within this context, "worsening" means a pathological or symptomatic

exacerbation resulting in increased loss in use or function since the August 1986 Determination Order, which closed the claim with no award of permanent disability. International Paper Co. v. Turner, 104 Or 354, on rem 91 Or App 91 (1988).

The best indication of claimant's condition at the time of the August 1986 Determination Order is a closing report from Dr. Karasek, claimant's treating neurologist, issued July 11, 1986. In that report, Dr. Karasek states that claimant's carpal tunnel "is not now symptomatic and is electrically resolved." We compare this description of claimant's condition to documented symptoms and objective findings in subsequent medical reports issued in late 1988. These reports describe the recurrence of electrical findings, right arm pain and numbness, and right thumb weakness in late 1988. As a result of this exacerbation, claimant's treating physician restricted her from further typing activity in January 1988.

Based on this evidence, we are persuaded that claimant experienced a compensable worsening of her right carpal tunnel condition no later than January 1988. Consequently, her worsening occurred prior to expiration of her aggravation rights in February 1989, so that we cannot close her claim under our own motion authority. The claim must, instead, be closed by the Evaluation Section under ORS 656.268. Accordingly, the request for own motion closure is dismissed, and we refer this matter to the Evaluations Section for closure.

IT IS SO ORDERED.

RENEE A. ANDERSON, Claimant
Francesconi & Associates, Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 87-12035 & 86-04852
December 11, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

The self-insured employer requests review of those portions of Referee Lipton's order that: (1) set aside its "de facto" aggravation denial of claimant's neck, left shoulder, and upper back conditions; and (2) upheld the SAIF Corporation's "new injury" denial of the same conditions.

The Board reverses the order of the Referee.

ISSUE

Whether claimant's injury of September, 1985, and her subsequent work activities at SAIF's insured, independently contributed to cause a worsening of her underlying conditions.

FINDINGS OF FACT

In February, 1983, claimant compensably injured her neck, left shoulder, and back, while working as a laborer for the employer, a lumber mill. She began treating with Dr. Robinson, a chiropractor. Robinson diagnosed a thoraco-cervical strain and took her off work. A Determination Order closed her claim in June, 1983, with no award of permanent disability. Thereafter, she was examined by several medical practitioners who corroborated Robinson's diagnosis and found no permanent impairment. In April, 1984, she began treating with Dr. Christensen, a chiropractor. Christensen filed an aggravation claim on her behalf, which was

denied by the employer. By way of a prior Referee's order, dated January 29, 1985, the employer's denial was set aside and claimant's 1983 claim was reopened.

Claimant continued to treat with Dr. Christensen, until she began working for SAIF's insured, a medical office, in August, 1985. While lifting a typewriter on September 17, 1985, she experienced a "snapping" sensation in her neck and left shoulder. She was examined by Dr. Leveque, a chiropractor, who recommended aggressive physical therapy. Despite the therapy, her condition worsened resulting in her voluntary termination from work in May, 1986. A Determination Order issued on May 9, 1986, closing the 1983 claim and awarding a period of temporary disability and 15 percent unscheduled permanent disability for her neck, left shoulder, and back conditions. A few days later, claimant was examined by Dr. Howell, an osteopath. Howell found that her underlying condition had worsened as a result of her clerical duties at SAIF's insured.

In June, 1986, the employer requested the issuance of an order pursuant to ORS 656.307. Later that month, claimant filed a "new injury" claim against SAIF. SAIF denied the claim on July 17, 1986.

In August, 1986, claimant was examined by the Orthopaedic Consultants. The Consultants found that claimant had experienced an exacerbation of her 1983 injury. Two weeks later, the Compliance Division issued a "307 order" designating SAIF as the paying agent.

In January, 1987, claimant was reexamined by Dr. Christensen.

ULTIMATE FINDING OF FACT

The September, 1985, typewriter lifting incident and claimant's subsequent work activities at SAIF's insured, independently contributed to cause a worsening of her underlying neck, left shoulder, and back conditions.

CONCLUSIONS OF LAW

The Referee found that claimant had sustained an aggravation of her February, 1983, injury, rather than a "new injury." We disagree.

At the outset, we note that claimant's February, 1983, claim remained open at the time of her alleged "new injury" in September, 1985. We, nonetheless, view the rule of law announced in the "successive injury" line of cases as the correct rule of law to follow. Harry A. Joers, 40 Van Natta 110, 111 rev'd on other grounds 41 Van Natta 849 (1989). Accordingly, the employer remains responsible for claimant's disability, unless work activities at SAIF's insured independently contributed to a worsening of her underlying conditions. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

Here, claimant's condition had steadily improved under Dr. Christensen's care. When she began working for SAIF's insured in August, 1985, she was experiencing no apparent difficulties. That changed on September 17, 1985, when she experienced acute pain in her shoulder and up into her neck. Despite reduced work

hours, her condition continued to deteriorate. By May, 1986, she was unable to continue working.

The medical evidence is divided. Drs. Christensen and Howell opine that claimant's work activities at SAIF's insured independently contributed to her disability. (Exs. 34-5 & 39-5). On the other hand, the Consultants opine that claimant's disability is a mere symptomatic exacerbation of her original 1983 injury. (Ex. 32A-5). We are persuaded by the collective opinions of Christensen and Howell, over that of the Consultants.

First, Christensen was claimant's treating doctor. Finding no persuasive reasons to do otherwise, we accord his opinion great weight. Weiland v. SAIF, 64 Or App 810 (1983). Second, unlike the Consultants, Christensen examined claimant at the critical times both before and after the lifting injury of September, 1985. Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986). Third, in our view, Christensen's opinion was corroborated by Dr. Howell. (Exs. 30-9 & 34-5). Last, the Consultants based their opinion on an incorrect medical history, stating, inter alia:

> "There was no specific incident. [Claimant] gradually developed symptoms in her neck and upper extremity which were recurrence of symptoms with which she had been suffering since a work incident in March of 1983." (Emphasis added).

Under such circumstances, we conclude that claimant's lifting injury of September, 1985, and her subsequent work activities at SAIF's insured, independently contributed to cause a worsening of her underlying neck, left shoulder, and back conditions.

ORDER

The Referee's order, dated March 25, 1988, is reversed. The employer's denial is reinstated and upheld. SAIF's denial is set aside and this claim is remanded to SAIF for processing according to law. SAIF shall reimburse the employer for its claim costs incurred to date. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $1,926.50.

ROLAND L. DAWKINS, Claimant
Vick & Associates, Claimant's Attorneys
Spears, et al., Defense Attorneys

WCB 85-11265
December 11, 1989
Order on Remand

This matter is before the Board on remand from the Supreme Court. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). The Court has held that, before a claimant is entitled to temporary total disability upon aggravation of a work-related injury, the claimant must be in the work force. The Court has reasoned that a claimant is deemed to be in the work force if: (1) the claimant is engaged in regular gainful employment; or (2) although not employed at the time, the claimant is willing to work and is making reasonable efforts to obtain employment; or (3 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. Reversing our prior order which held that claimant was not entitled to temporary total disability, the Court has remanded

with instructions to "find whether claimant had withdrawn from the work force at the time of the aggravation of his prior work-related injury."

FINDINGS OF FACT

Claimant was 60 years old at the time of hearing. He has an eighth grade education. For 25 years prior to his 1982 compensable motor vehicle accident, claimant had worked as a truck driver. As a result of the accident, he suffered several injuries, the most serious of which was a subdural hematoma. Brain surgery was performed, but claimant was left with significant deficits in his cognitive abilities.

Claimant has not worked since the 1982 accident. A February 1984 Determination Order awarded 55 percent (176 degrees) unscheduled permanent disability. This award was increased to 85 percent (272 degrees) by a March 1984 stipulation.

On the advice of his physicians, claimant had not looked for work because of limitations due to his physical and mental conditions. His vocational assistance was discontinued for the same reasons. At the time of his July 1985 aggravation, claimant would have preferred to be back to work and had not considered retirement.

At the time of his July 1985 aggravation claim, claimant was receiving Social Security disability payments and Teamster's Union disability benefits. He was not receiving retirement benefits.

ULTIMATE FINDINGS

As of July 1985, claimant was willing to work. He was not seeking work, but any efforts by him to obtain employment would have been futile. Claimant had not withdrawn from the work force.

CONCLUSIONS

A claimant who has withdrawn from the work force at the time of an aggravation of a compensable injury is not entitled to temporary total disability. Cutright v. Weyerhaeuser, 299 Or 290, 293 (1985). However, when a prior compensable injury prevents a claimant from securing employment, the claimant may be deemed to remain in the work force. Dawkins v. Pacific Motor Trucking, supra, 308 Or at 257.

The Dawkins court listed three situations when a claimant is deemed to be in the work force:

> "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, Cutright v. Weyerhaeuser, supra, see ORS 656.206(3); 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. Cf. SAIF v. Stephen, 308 Or 41, 47-48 (1989)." Dawkins, supra, 308 Or at 258.

The Court in Dawkins reasoned that the extent of a claimant's permanent partial disability and a worsened condition may excuse the requirement that a claimant make reasonable efforts to obtain employment. Dawkins v. Pacific Motor Trucking, 308 Or at 258. In those extraordinary circumstances where, as a result of a compensable condition, any attempt to seek employment would be futile, a claimant is deemed to be in the work force provided that he is otherwise willing to work. Id. Such a claimant would be entitled to receive temporary total disability benefits upon aggravation of the compensable injury.

Here, claimant suffers from organic brain dysfunction. Several examining physicians have stated that he may not work at his previous employment. Furthermore, without retraining, he lacks transferable skills. Yet, in April, 1984, claimant's vocational assistance was terminated by Germain-Bennett because claimant's physical and mental conditions interfered to such a degree that they would prevent the success of any vocational assistance. Any such assistance would "not resolve the lack of suitable employment" for him.

Since his compensable injury and the termination of his vocational assistance, claimant has not actively sought work nor has he plans to do so. Despite these circumstances, claimant chose to receive disability, rather than retirement, benefits from Social Security and the Teamsters' program. When asked whether he was satisfied with his situation, claimant stated "[w]ell, personally I'd like to get back to work, yeah. Shoot. But the doctors just told me I couldn't, so I just settled for my disability." (Tr. 8).

Based on the above, we find that claimant remained willing to work but was not making efforts to obtain employment at the time of his aggravation claim because such efforts would have been futile. Under such circumstances, claimant is deemed to be in the work force and, as such, entitled to temporary disability benefits. Dawkins v. Pacific Motor Trucking, supra, 308 Or at 258 (1989); SAIF v. Stephen, supra.

Accordingly, claimant is awarded temporary total disability benefits between July 26, 1985 and March 20, 1986. In accordance with claimant's retainer agreement, claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $750.

IT IS SO ORDERED.

RAMONA S. DOUGHERTY, Claimant
Johnson, Cram, et al., Claimant's Attorneys
Nancy Meserow, Defense Attorney
Acker, et al., Defense Attorneys

WCB 87-04445 & 87-10860
December 11, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Liberty Northwest Insurance Corporation requests, and claimant cross-requests, review of those portions of Referee Peterson's order that: (1) set aside its "new injury" denial of claimant's back condition; and (2) upheld Wausau's Insurance Company's aggravation denial for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

On November 14, 1985, claimant compensably injured her back while working for Wausau's insured. Claimant complained of back pain in the left mid thoracic and lumbar region. Claimant was treated conservatively, and was released to work on December 10, 1985, at which time her condition was considered to be medically stationary. (Ex. 4). She did not return to work, however, because Wausau's insured had terminated her position. The claim was closed by Determination Order without an award of permanent disability.

Claimant continued to experience back pains, for which she received conservative treatment. In September 1986, she began work with Liberty Northwest's insured. On January 16, 1987, she filed a claim with Liberty Northwest for a low back strain. No specific incident was identified.

Liberty Northwest denied the "new injury" claim alleging that claimant's condition was related to the November 14, 1985 injury. Thereafter, Wausau denied claimant's aggravation claim.

ULTIMATE FINDINGS OF FACT

Claimant's employment with Liberty Northwest's insured did not independently contribute to a worsening of her underlying back condition.

CONCLUSIONS OF LAW

The Referee stated that the basic question was whether claimant's work at Liberty Northwest's insured had independently contributed to claimant's worsened back condition. The Referee found persuasive, Dr. Denker's opinion that claimant's January 1987 work contributed to a worsening of her back condition. As a result, the Referee reasoned that claimant had sustained a "new injury" for which Liberty Northwest was responsible. We disagree.

Responsibility remains with Wausau, unless the "new injury" independently contributed to claimant's disability (i.e., caused a worsening of her underlying condition). Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986); Theodore R. Stoller, 41 Van Natta 303, 1305 (1989). In addition, when there is a dispute between medical experts, more weight will be given to the opinion which is well reasoned and based on a complete history. Somers v. SAIF, 77 Or App 259, 263 (1986); Clifford J. Wadkins, 41 Van Natta 1529, 1530 (1989).

Claimant's work at Liberty Northwest's insured did not

independently contribute to a worsening of her back condition. Dr. Denker, M.D., a specialist in industrial medicine, initially opined that claimant's current difficulties represented an aggravation of her November, 1985 injury. Nevertheless, Dr. Denker subsequently reversed his prior conclusions, stating that claimant's underlying condition worsened. In so doing, Dr. Denker admitted that he was essentially unaware of what objective findings claimant had following the 1985 injury, thereby acknowledging an incomplete medical history. A medical opinion is persuasive only to the extent that the underlying basis is free from deficiency. Miller v. Granite Construction, 28 Or App 473, 476 (1976). Since Dr. Denker has based his diagnosis on an incomplete medical history, we do not find his opinion persuasive.

On the other hand, Dr. McKillop, a specialist in orthopedic surgery and fractures, was in a superior position to offer a medical opinion. Specifically, he was the only physician who examined claimant both before and after the January, 1987, alleged "new injury". Kienow's Food Store, Inc. v. Lyster, 79 Or App 416 (1986). Dr. McKillop concluded that the January 16, 1987, episode represented a temporary increase in symptoms of claimant's back condition, but not a worsening of her underlying condition. Dr. McKillop's opinion was well reasoned and based on claimant's complete medical history. Consequently, we find Dr. McKillop's conclusions persuasive.

Accordingly, we conclude that the January 16, 1987 episode did not independently contribute to a worsening of claimant's underlying back condition. Responsibility for claimant's current back disability remains with Wausau.

ORDER

The Referee's order, dated May 27, 1988, is reversed. Liberty Northwest's denial is reinstated and upheld. Wausau's denial is set aside and Wausau is directed to process the claim according to law. Wausau shall reimburse Liberty Northwest for its claim costs incurred to date. A client-paid fee, payable from Liberty Northwest to its counsel, is approved, not to exceed $1,112.

LYNN M. ELLIOTT, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-05171, 86-15343, 86-15352, 87-15114 & 87-15115
December 11, 1989
Order of Withdrawal

Claimant has requested reconsideration of our November 15, 1989, Order on Review. In so doing, he argues that Member Cushing should recuse himself from this case. We address the issue of recusal.

In 1987, Member Cushing served as an arbitrator in an employment termination proceeding involving claimant and the employer. A decision was rendered by Member Cushing in April, 1987, finding against claimant.

Shortly after receipt of claimant's recusal request, dated December 6, 1989, Member Cushing checked his personal records to verify whether he had served as an arbitrator in a 1987 proceeding involving claimant and the employer. After doing so, he was able to verify that he had, in fact, served as an arbitrator in such a proceeding. Under such circumstances, Member Cushing agrees that he should have recused himself from this case.

Member Cushing wishes to make clear, however, that until receipt of claimant's recusal request, he was unaware of any prior involvement between himself and the parties in his former role as an arbitrator. That is, until December 6, 1989, Member Cushing was not aware of the fact that the instant parties were the same parties involved in the 1987 arbitration proceeding.

Accordingly, Member Cushing has recused himself from this case. In order to allow sufficient time for the Board to reconsider this case, our November 15, 1989, order is withdrawn. The Board shall further consider this case.

IT IS SO ORDERED.

DOROTHY A. AMSTUTZ, Claimant
Heiling & Morrison, Claimant's Attorneys
Acker, et al., Defense Attorneys
Ronald Pomeroy (SAIF), Defense Attorney

WCB 87-03560, 87-13735, 87-16658 & 87-16659
December 12, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

International Paper Company, a self-insured employer, requests review of Referee Miller's order that set aside its denial of claimant's accidental injury claim relating to her upper back and its denial of claimant's occupational disease claim relating to her wrists. Claimant cross-requests review of that portion of the order that awarded his attorney an assessed fee of $1,950. The issues are compensability, responsibility and attorney fees. We reverse in part.

FINDINGS OF FACT

Claimant began working as a seedling grader for International Paper Company (IP), a self-insured employer, on December 10, 1986. In this position, she separated and sorted tree seedlings at a rate of about 1,200 per hour. After her first few days of work, she began to experience soreness in her upper back and a feeling of numbness and tingling in her hands. Then, on December 16, 1986, she experienced a sudden increase in upper back pain about midway through her shift. She sought medical treatment later the same day from Dr. Daskalos, an osteopath. He diagnosed a thoracic strain, took her off work for the next week and then released her to return to work without restrictions. Claimant filed a workers' compensation claim for her upper back injury on December 17, 1986.

On January 8, 1987, claimant was involved in an automobile accident while driving to work. Her vehicle flipped onto its right side and she fell from the driver's seat to the passenger door. As a result of the accident, claimant experienced a mild concussion, general soreness and a feeling of numbness or paralysis in the right upper quadrant of her body. On February 5, 1987, IP issued a denial of claimant's claim relating to her upper back on the ground that her "current condition," i.e., her condition at the time of the denial, was not related to her employment. Claimant timely requested a hearing on the denial.

Claimant recovered sufficiently from the injuries sustained in the motor vehicle accident to return to work on January 17, 1987. In mid-February 1987, the numbness and tingling

which she had experienced in her hands worsened. She sought medical evaluation of her condition on February 22, 1987, but continued working. Her employment with IP was seasonal and was terminated at the end of February 1987. Her hand symptoms improved after that, but did not completely resolve. She filed a claim with IP for her wrist condition on March 16, 1987.

On May 13, 1987, claimant began working as a maid for the Budget Six Motel (Budget Six). This job involved stripping and making beds, vacuuming, scrubbing bathrooms, washing windows and dusting. During the month following her employment with Budget Six, claimant's hand symptoms returned at least to the level at which they had been in late February 1987 and she was unable to continue performing some of her duties as a maid. Because of this, her employment with Budget Six was terminated on June 15, 1987.

Claimant subsequently sought treatment for her wrist condition from Dr. Golden, a neurosurgeon. He diagnosed carpal tunnel syndrome and performed surgery on both wrists. IP denied the compensability of claimant's wrist condition on August 28, 1987. Claimant filed a request for hearing on this denial which was consolidated with her previous hearing request on the denial of her upper back condition.

IP's denials came to hearing before Referee Garaventa on October 13, 1987. During this hearing, counsel for IP learned for the first time of claimant's employment with Budget Six and moved to join that employer and its insurer. The hearing was discontinued and Budget Six and its insurer, the SAIF Corporation, were joined as parties. The matter was then reset and came to hearing before Referee Miller on January 4, 1988. SAIF never issued a formal denial of claimant's wrist condition, but counsel for SAIF orally denied the claim on responsibility grounds at the beginning of the hearing. Neither SAIF nor any other party applied for an order pursuant to former ORS 656.307 and none was issued. Claimant's attorney participated in both of the hearing sessions in this case and in two depositions. He spent a total of 33.20 hours on the case at the hearing level. The Referee awarded him a fee payable by IP in the amount of $1,950.

Carpal tunnel syndrome is a symptom complex affecting the wrist and hand and is caused by compression of the median nerve within the carpal tunnel. This compression results from inflammation or other changes in the tissues within the tunnel. Such changes can result from repetitive hand or wrist movements or stresses.

FINDINGS OF ULTIMATE FACT

1. Claimant sustained a thoracic strain on December 16, 1986. The strain resulted in disability and required medical evaluation and treatment. Claimant's work activity for IP was a material contributing cause of the strain.

2. Claimant was first disabled and sought medical treatment for her upper back strain on December 16, 1986. Claimant returned to work on December 23, 1986 and was not thereafter disabled by the condition and did not seek medical treatment for the condition.

3. Claimant developed carpal tunnel syndrome between

December 10, 1986 and June 15, 1987. The condition required medical evaluation and treatment and ultimately resulted in disability. Claimant's work activity for IP and Budget Six was the major contributing cause of the condition.

4. Claimant first sought medical treatment for her carpal tunnel syndrome on February 22, 1987, while she was employed by IP. She was first disabled as a result of the condition on June 15, 1987, after her employment with Budget Six. Claimant's work activity both at IP and Budget Six was of a kind which could cause carpal tunnel syndrome over an indefinite period of time.

CONCLUSIONS OF LAW

1. Compensability of Claimant's Upper Back Strain

Claimant's claim for an upper back strain is one for accidental injury under former ORS 656.005(8)(a). Under that section, claimant has the burden of proving "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death."

In the present case, claimant established that her work activity resulted in a strain of her upper back. This strain resulted in disability and required medical services. Claimant, therefore, established a compensable accidental injury. The fact that claimant may have subsequently injured the same area of her body in an off-work motor vehicle accident (a question which is not before us and which we do not decide) does not render her upper back strain noncompensable ab initio. If IP contends that the motor vehicle accident terminated its responsibility for claimant's upper back strain after the date of the motor vehicle accident, it should issue a partial denial to that effect once it has processed claimant's compensable claim to closure.

2. Responsibility for Claimant's Upper Back Strain

Claimant's upper back condition did not worsen as a result of her employment with Budget Six. Responsibility for that condition, therefore, does not shift; it remains with IP. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

3. Compensability of Claimant's Carpal Tunnel Syndrome

Claimant's claim for carpal tunnel syndrome is one for occupational disease under former ORS 656.802(1)(a). Under that section, claimant must prove that her work activity or exposure was the major contributing cause of a disease or infection or of a pathological worsening of a preexisting disease or infection. See Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979).

There are two primary medical opinions in the present case regarding the nature of carpal tunnel syndrome and the effect of claimant's work activities on the development of her condition. The first opinion is from Dr. Golden, claimant's treating physician. Dr. Golden is a neurosurgeon with many years of experience in the treatment of carpal tunnel syndrome. He opined that carpal tunnel syndrome is caused by compression of the median nerve resulting from changes in the tissues within the carpal tunnel and that claimant's work activity for IP and Budget

Six was the primary, if not sole, cause of such tissue changes in claimant's wrists.

The second opinion is from Dr. Nathan, a consulting hand specialist. Dr. Nathan opined that carpal tunnel syndrome is the symptomatic manifestation of an underlying condition called "carpal tunnel disease." Carpal tunnel disease, according to Dr. Nathan, is the abnormal but asymptomatic slowing of the median nerve within the carpal tunnel. This slowing is caused by an insufficient supply of oxygen to the median nerve. The reason for this oxygen insufficiency is unknown, but apparently it is related to the natural aging process. Any bodily activity which increases the need of the muscles for oxygen decreases the amount of oxygen available for the median nerve. This may cause carpal tunnel disease to become at least temporarily symptomatic and thus to manifest itself as carpal tunnel syndrome, but generally does not affect the underlying carpal tunnel disease process. Dr. Nathan conceded that his understanding of carpal tunnel syndrome represents a minority view in the medical community. Based upon this view, he opined that claimant has carpal tunnel disease and that her work activity for IP and Budget Six had resulted in an increase in the symptoms of this disease. He also opined, however, that the worsening of symptoms did not reflect a worsening of the underlying condition. Dr. Nathan recognizes surgical removal of the carpal ligament as an effective treatment for carpal tunnel syndrome.

The Referee accepted Dr. Golden's opinion and concluded that claimant's carpal tunnel syndrome was compensable. We agree with the Referee that Dr. Golden's opinion is more persuasive than Dr. Nathan's. Dr. Golden has considerable expertise in the diagnosis and treatment of carpal tunnel syndrome. His opinion is that claimant's work at IP caused the pathological changes diagnosed as carpal tunnel syndrome. His explanation of that opinion is logical, is consistent with the history provided by claimant and is based upon an understanding of the nature of carpal tunnel syndrome held by the majority of physicians. Dr. Nathan also has considerable expertise in the diagnosis and treatment of carpal tunnel syndrome. His opinion, however, is based upon a minority view of the nature of carpal tunnel syndrome and is internally inconsistent. He recognized surgical removal of the carpal ligament as an effective treatment of carpal tunnel syndrome. Such treatment would seem to logically affect carpal tunnel syndrome only if the condition was affected by compression of the median nerve within the tunnel. Dr. Nathan gave no explanation of how such a procedure would affect the oxygen reaching the nerve assuming, as he did, that carpal tunnel syndrome is not caused by compression of the median nerve.

In view of our acceptance of Dr. Golden's opinion, we find that claimant's work activity at IP and Budget Six was the major contributing cause of inflammation or other changes within claimant's carpal tunnel which resulted in her carpal tunnel syndrome. This condition resulted in disability and required medical services. It follows that claimant has proven a compensable occupational disease.

4. <u>Responsibility for Claimant's Carpal Tunnel Syndrome</u>

The Referee assigned responsibility for claimant's carpal tunnel syndrome to IP on the ground that the evidence

failed to support the conclusion that claimant's underlying condition worsened as a result of her work activity at Budget Six. We agree with the Referee that the evidence is inconclusive on the question of whether claimant's work activity at Budget Six actually worsened her underlying condition. We conclude, however, that SAIF, the insurer of Budget Six, had the burden of persuasion on the responsibility issue and assign responsibility to SAIF on that basis.

Responsibility for a compensable occupational disease is determined by the last injurious exposure rule. Bracke v. Baza'r, Inc., 293 Or 239, 246 (1982). In a case such as this where disability first occurs after a series of two or more potentially causal employments, the key event for assigning responsibility under that rule is the date of disability. Id. at 248-49. The date of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date upon which the claimant first seeks medical treatment for the condition. Cleo M. Riggs, 40 Van Natta 1133, 1136, 40 Van Natta 1572 (1988); see United Pacific Insurance Co. v. Harris, 63 Or App 256, 260, rev den 295 Or 730 (1983).

The last carrier on the risk prior to the date of disability whose employment involved potentially causal conditions is responsible for the claimant's entire condition unless it establishes that the employment activity or exposure during its period of coverage did not actually contribute to the cause of the claimant's underlying condition or that subsequent employment activity or exposure under another carrier's coverage actually did contribute to the cause of the claimant's underlying condition. Bracke v. Baza'r, Inc., supra, 293 Or at 248-51; Fossum v. SAIF, 293 Or 252, 256 n.1 (1982); FMC Corp. v. Liberty Mutual Insurance Co., 70 Or App 370, 374 (1984), modified 73 Or App 223, rev den 299 Or 203 (1985). Potentially causal conditions are conditions which could cause the claimed disease over some indefinite period of time; proof of actual medical causation is not required. Fossum v. SAIF, supra, 293 Or at 256; Meyer v. SAIF, 71 Or App 371, 374 (1984), rev den 299 Or 203 (1985).

In the present case, claimant first sought medical treatment for her condition during her employment with IP. She did not become disabled, however, until after her employment with Budget Six. Because claimant became disabled, the date of disability is the critical date for fixing responsibility. Hence, Budget Six and SAIF are responsible unless the record establishes that claimant's work activity for Budget Six did not actually contribute to the cause of claimant's underlying carpal tunnel syndrome. Dr. Golden opined and we found as fact that claimant's work activity for Budget Six could have caused or contributed to carpal tunnel syndrome over some indefinite period of time. Golden was unable to say, however, and we were unable to determine whether or not that work activity actually did contribute to the cause of the condition. On this record, we conclude that SAIF has failed to establish that claimant's underlying condition was due solely to her work activity for IP. Consequently, SAIF is responsible.

5. Attorney Fees

The Referee awarded claimant's attorney an attorney fee of $1,950 in connection with the setting aside of IP's denials.

Claimant contends that this fee was inadequate. We agree. Considering the detailed statement of services submitted by claimant's attorney and the factors enumerated in OAR 438-15-010(6), we award claimant's attorney a reasonable fee of $2,500. For the reasons stated below, we further conclude that this fee should be assessed against IP.

In its respondent's brief, SAIF contended that should responsibility be assigned to it, IP should still be responsible for claimant's attorney fee under the rule of Karen J. Bates, 39 Van Natta 42 (1987), rev'd in part on other grounds, 94 Or App 666 (1989). We agree.

Admittedly, unlike the carrier relieved of paying the attorney fee in Bates, SAIF did not apply for the issuance of an order pursuant to former ORS 656.307. Here, however, SAIF was not a party to the hearing until after the proceedings had already commenced. In fact, the initial hearing was discontinued to permit the joinder of SAIF as a party. Thus, by the time SAIF entered the case, the case was already in litigation. Moreover, despite SAIF's oral responsibility denial, IP's compensability denial would have prohibited the issuance of a .307 order.

In accordance with the principles espoused in Bates, to avoid responsibility for attorney fee awards for claimant's consel's services at hearing, carriers should comply with their duties under OAR 436-60-180. Yet, under these circumstances, we conclude that SAIF's failure to seek an order designating a paying agent does not cause us to refrain from applying the Bates rationale. Accordingly, we hold that IP is not relieved of responsibility for claimant's attorney fee for services at hearing.

Claimant's attorney is also entitled to a fee payable by IP for services rendered on Board review. See ORS 656.382(2); SAIF v. Bates, 94 Or App 666, 669-71 (1989). No fee has been awarded, however, because the attorney has not filed a statement of services rendered on Board review. See OAR 438-15-010(5).

ORDER

The Referee's order dated April 21, 1988 is affirmed in part and reversed in part. Paragraphs 3, 5 and those portions of paragraph 1 of the order that set aside International Paper Company's denials of February 5, 1987 relating to claimant's upper back injury and of August 28, 1987 relating to the compensability of claimant's carpal tunnel syndrome are affirmed. The remainder of the Referee's order is reversed. The SAIF Corporation's "de facto" denial of claimant's occupational disease claim for carpal tunnel syndrome is set aside and the claim is remanded to SAIF for processing according to law. International Paper Company's "de facto" denial of responsibility for claimant's carpal tunnel syndrome is reinstated and upheld. International Paper shall pay claimant's attorney an assessed fee of $2,500 for services at hearing. A client-paid fee of up to $391 for counsel for International Paper Company is approved.

REUBIN B. COLEMAN, Claimant
Royce, et al., Claimant's Attorneys
Terrall & Miller, Defense Attorneys

WCB 87-16252
December 12, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of that portion of Referee Knapp's order which set aside its denial of claimant's occupational disease claim for a respiratory condition. In his brief, claimant contends that the Referee's award of attorney fees, for overcoming the employer's denial, should be increased. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

The employer manufactures mining equipment. For storage and shipping of parts and equipment, rust inhibitors were used, specifically LPS-3 and Rust-Veto. The major ingredient in both products was a petroleum aliphatic solvent. The process of spraying parts with LPS-3 and Rust-Veto had been performed in a ventilated paint room until mid-1985 when the process was relocated in the warehouse.

Claimant worked for the employer as a warehouseman in the receiving department. He, and other workers, were exposed to the vapors of the rust inhibitors from the fan drying of the parts dipped in Rust-Veto and from hand spraying LPS-3 on other parts for packaging. Claimant used LPS-3 four to five hours per day, spraying parts in plastic bags. Spraying and bag leakage saturated the wood tables. There were strong vapors where the parts were stored. Generally, the workers did not wear protective clothing or masks.

In September 1986, claimant sought treatment from Dr. Eubanks, his family physician, for complaints of stomach and chest discomfort. Claimant continued to experience symptoms and Dr. Eubanks released claimant from work in May 1987. By June 1987, claimant was experiencing a progressive cough, chest tightness, and shortness of breath. Dr. Eubanks referred claimant to Dr. Morton, head of the occupational health clinic at the Oregon Health Sciences University. On June 16, 1987, claimant filed a claim for a respiratory condition, noting bleeding sinuses and breathing difficulties.

In July 1987, Dr. Morton released claimant to work, with the limitation that he avoid chemical fumes. The employer initially placed claimant in another part of the work site, but he continued to experience symptoms and was transferred to perform office work in July 1987. Also, in July 1987, claimant underwent pulmonary function studies. The studies were normal including a negative methacholine bronchial challenge. In October 1987, the employer denied claimant's claim for a respiratory condition. At this time, challenge tests were performed using LPS-3 and Rust-Veto. Both substances showed negative bronchial provocation.

Claimant was then referred to Dr. Keppel, a lung specialist. On November 9, 1987, following a negative challenge test to LPS-3, Dr Keppel released claimant to his regular work, but recommended respiratory protection. Dr. Keppel saw claimant again on November 20, 1987 and felt claimant was extremely depressed. He authorized time loss for this condition.

From 1977 through 1983, claimant occasionally complained of sinus congestion and respiratory problems to the employer's nurse. In 1979, claimant had a reaction to tricholethylene that was being used at work. He experienced headaches, nausea, sore throat and coughing. Claimant was removed from the area in which the chemical was used and his symptoms decreased.

Claimant develops symptoms when exposed to smoke, including cigarette smoke, dog hair, vehicle exhaust, dust, oils, deodorants, paint, and solvent fumes.

CONCLUSIONS OF LAW

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

In order to prevail on an occupational disease claim, claimant must show that the work activity either caused the condition or, in the case of a preexisting condition, that the work activities caused a worsening of the underlying condition. Wheeler v. Boise Cascade, 298 Or 452 (1985).

In the present case, there is no persuasive evidence that claimant's rhinosinusitis condition preexisted his employment. Although, the employer's nurse did report that claimant had occasionally complained of sinus and respiratory symptoms between 1977 and 1983, there is no history which establishes a long term or chronic condition. Claimant's current symptomatology did not appear until late 1986, after exposure to the rust inhibitor fumes. Accordingly, the evidence does not establish that claimant has a preexisting respiratory condition, therefore, he need not prove a worsening of his rhinosinusitis condition. Wheeler, supra. Nonetheless, he must show that his work activities were the major contributing cause of the development of his respiratory condition. Devereaux v. North Pacific Ins. Co., 74 Or App 388, 391-92 (1985)

Dr. Morton opined that claimant suffered from chronic sinusitis as a result of his exposure to fumes at work. Dr. Miles also opined that claimant's respiratory condition is work-related. Dr. Keppel originally opined that claimant's condition was related to his work exposure, however, following the negative challenge tests, he changed his opinion and felt that claimant may have had a neuropsychiatric response. Dr. Bardana reported that claimant had no objective signs of nasal, sinus or pulmonary disease. He opined that claimant had a mild form of chronic sinusitis that was unchanged by claimant's exposure to either LPS-3 or Rust-Veto.

We are persuaded by the well-reasoned opinion of Drs. Bardana and Keppel. Drs. Morton and Miles do not adequately explain how claimant's exposure to LPS-3 and Rust-Veto are causative of his respiratory condition, when challenge tests involving those substances were negative. Further, Dr. Morton did not take an off-work exposure history and was apparently unaware that claimant experienced symptoms when exposed to various substances not present at his work place.

Under these circumstances, we conclude that claimant has not established that his work exposure to solvent fumes was the major contributing cause of his respiratory condition.

As we have upheld the employer's denial, we do not reach claimant's cross-request for increased attorney fees.

ORDER

The Referee's order, dated March 9, 1988, is reversed in part and affirmed in part. That portion which set aside the self-insured employer's denial is reversed. The employer's denial is reinstated and upheld and the Referee's award of an assessed fee for setting aside the denial is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $2,019, is approved.

ELIZABETH COOMER, Claimant
Murphy & Lawrence, Claimant's Attorneys
Shelley McIntyre (SAIF), Defense Attorney
Nelson, et al., Defense Attorneys
Nancy J. Meserow, Defense Attorney

WCB 88-00013, 88-00014, 88-00015 & 88-00016
December 12, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Wausau Insurance Companies (Wausau) requests review of those portions of Referee Bennett's order that: (1) set aside its aggravation denial of claimant's low back condition; and (2) upheld both the SAIF Corporation's (SAIF's) aggravation denial and Liberty Northwest Insurance Corporation's (Liberty Northwest's) "new injury" denial for the same condition. On review, the issues are compensability and responsibility.

The Board reverses the order of the Referee.

FINDINGS OF FACT

This case involves one employer, a plating shop, who has been successively insured by SAIF, Wausau, and Liberty. Claimant, 45, worked as a "racker" for the employer, until approximately 1987. As a "racker," she was regularly lifting, pushing, and pulling objects that ranged in size and weight from dental to automobile parts.

While SAIF was at risk, claimant sustained compensable low back injuries in March, 1976, and October, 1976. The first injury caused only a strain, which fully resolved in a couple of months with no permanent impairment. The second injury, however, caused a sacral contusion and one week of hospitalization. In addition, since that time, claimant has been bothered by ongoing low back discomfort and radiating right leg pain. A May, 1978 Determination Order closed the October, 1976 injury, with an award of 10 percent unscheduled permanent disability.

In October, 1982, after Wausau had commenced its coverage, claimant sustained her third compensable injury, an acute lumbosacral strain. Like her March, 1976 injury, however, this third injury resulted in only a temporary lumbar strain. The following month, claimant returned to regular work with no apparent increased permanent impairment. Wausau accepted the October, 1982 claim and closed it by way of a November 17, 1982 Notice of Closure, with no permanent disability.

Despite continuing symptoms of low back and right leg pain, claimant continued to work and did not seek further medical

treatment until January, 1986. X-rays performed at that time revealed some chronic narrowing of the L5 and S1 disc spaces, but no "great deformity." Her condition was diagnosed as a "recurrent" low back strain and she was placed on light duty work. In December, 1986, she was examined by Dr. Schaub, M.D. Schaub suspected a herniated lumbar disc, which was confirmed by a CT Scan in February, 1987.

Liberty Northwest commenced its coverage on April 1, 1987. By that time, the employer had transferred claimant to a light duty clerical position. Nonetheless, she was unable to continue working beyond August 18, 1987, due to increased low back and right leg pain. A few days later, she was examined by Dr. Wilson, M.D., who, inter alia, diagnosed a lumbar disc protrusion and recommended surgical intervention.

In September, 1987, Liberty Northwest formally denied responsibility for claimant's alleged "new injury." In so doing, it requested the issuance of an ORS 656.307 order. However, no ".307" order was forthcoming.

The following month, claimant was examined by the Orthopaedic Consultants, as well as Dr. Jannuzzi, M.D. These experts concurred with Dr. Wilson's diagnosis and recommendation for surgery.

In January, 1988, Wausau formally denied an aggravation of the compensable October, 1982 injury. At the hearing, Wausau's counsel argued that it was denying both compensability and responsibility. Likewise, SAIF's counsel stated that it was denying both compensability and responsibility for an alleged aggravation of either of the two accepted 1976 injuries. The record contains no formal denial from SAIF.

ULTIMATE FINDINGS OF FACT

Claimant's work activities from April, 1987 through August 18, 1987, while Liberty Northwest was at risk, did not independently contribute to the causation of her disabling condition. Claimant's October 1982 injury, while Wausau was at risk, did not independently contribute to the causation of her current condition. Her October, 1976 injury, while SAIF was at risk, resulted in continuing low back and right leg symptoms. Following closure of the 1976 injury claim in May 1978, claimant's symptoms gradually increased to the point that she could not continue working beyond August 18, 1987.

CONCLUSIONS OF LAW

The Referee found that Wausau was the responsible insurer inasmuch as it allegedly issued an impermissible "back-up" denial of the compensable October, 1982 injury. We disagree.

Wausau did nothing more than to issue an aggravation denial. Its denial of January, 1988 neither directly nor indirectly suggested that it was denying the previously accepted 1982 claim. See Ebbtide Enterprises v. Tucker, 303 Or 459 (1987); Bauman v. SAIF, 295 Or 788 (1983). Accordingly, we turn to the merits.

Compensability

When compensability and responsibility are both at issue, as here, the threshold issue is compensability. Runft v. SAIF, 303 Or 493, 498-99 (1987).

March, 1976 Injury

Claimant's March, 1976 injury resulted in only a temporary low back strain. A few months later, she was declared medically stationary and returned to regular work with no permanent impairment. Accordingly, we find no persuasive evidence of a causal contribution between the compensable March, 1976 injury, and claimant's alleged worsening in August, 1987.

October, 1976 Injury

Inasmuch as claimant's aggravation rights with respect to the October, 1976 injury, have expired, see ORS 656.273(4)(a) & 656.278(1)(a), we have jurisdiction to consider only whether she is entitled to current medical services. See ORS 656.245(1). The question of whether claimant's October 1976 injury claim may be reopened must be addressed under our Own Motion authority. See Elizabeth Coomer, 41 Van Natta 2304 (Issued this date).

The October, 1976 injury resulted in a period of hospitalization and, more importantly for causation purposes, continuing low back and right leg symptoms. The evidence establishes that claimant's October, 1976 injury materially contributed to her need for medical treatment in 1987. Accordingly, we conclude that claimant has proven the compensability of her current low back and right leg conditions, as to at least one of the insurers.

Responsibility

Having determined that claimant's condition is compensable, we turn to the issue of responsibility between the three insurers. In Hensel Phelps v. Mirich, 81 Or App 290, 294 (1986), the court provided that responsibility does not shift, unless work activities at the later insurer independently contribute to the causation of the worker's disability. Mere increased symptoms alone, without a worsening of a worker's underlying condition, does not shift responsibility. Id.

Here, Dr. Wilson stated, inter alia:

> "The [claimant's] difficulties are attributable to an injury in 1976 when she fell off a walk at work and landed on her back. She has since that time had continuing low back pain. She has intermittent episodes several times a year, in the past year she has had 4-5 episodes. This however, is the first time she has had right sciatic radiation with radiation to her foot." (Emphasis added).

Similarly, the Consultants opined, inter alia:

> "It is the impression of the panel that

> this patient did not have any specific injury on August 18, 1987. Her problem is one of gradual onset of back pain with relatively recent acceleration over the last 1 1/2 years. We do not feel that the August 18, 1987 date is of any importance." (Emphasis added).

Lastly, Dr. Jannuzzi reported, inter alia:

> "[Claimant's] symptoms have been present intermittently over the last 10 years, but much more severely since August of this year." (Emphasis added).

After our de novo review, we are not persuaded that claimant's light duty work activities, from April, 1987 through August 18, 1987, independently contributed, even slightly, to the causation of her disabling condition. There is no persuasive evidence linking her clerical duties during that period to her increased low back and right leg symptoms. Moreover, claimant herself conceded that there was no incident or trauma on August 18, 1987.

This is a case of continuing symptoms resulting from the October, 1976 injury, which gradually increased over the course of several years. Unlike the October, 1976 injury, the subsequent October, 1982 injury quickly resolved without increasing claimant's permanent impairment. Within a few days, she returned to regular work and did not seek further medical treatment for over four years. Furthermore, the mere fact that Wausau accepted claimant's acute low back strain as temporarily disabling does not prove a worsening of claimant's prior permanent, underlying low back condition. That temporary disability in 1982 may just as well have resulted solely from increased symptoms.

In any case, in the light of medical evidence causally linking her disability in 1987 to the October, 1976 injury, but not the 1982 injury, we conclude that SAIF is the responsible insurer for claimant's disabling low back and right leg conditions.

Claimant's attorney is entitled to a reasonable assessed fee for services on Board review. To date, however, we have not received a statement of services from claimant's attorney. Accordingly, we are unable to presently award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order, dated April 15, 1988, is reversed in part. The Saif Corporation's "de facto" medical services denial is set aside and the denials of Wausau Insurance Companies and Liberty Northwest Insurance Corporation are upheld. SAIF is directed to process the claim according to law. SAIF, rather than Wausau, is responsible for claimant's attorney fee for services at hearing.

ELIZABETH COOMER, Claimant
Murphy & Lawrence, Claimant's Attorneys
Shelley McIntyre (SAIF), Defense Attorney
Nelson, et al., Defense Attorneys
Nancy J. Meserow, Defense Attorney

WCB 87-0620M
December 12, 1989
Own Motion Order

Reviewed by Board Members Howell and Speer.

Claimant has requested that the Board exercise its Own Motion authority and reopen her compensable October, 1976 low back injury claim. Her aggravation rights under that claim have expired. In addition to the October, 1976 injury, claimant sustained a compensable October, 1982 injury, and an alleged "new injury" in August, 1987. Three different insurers were at risk at the time of each of those injuries.

Accordingly, claimant requested a hearing to resolve the issue of which insurer, if any, was responsible for her disabling low back condition. On April 15, 1988, a Referee issued an Opinion and Order, which concluded that, inter alia, claimant's disabling condition was the responsibility of Wausau Insurance Companies, as the insurer who had accepted the October, 1982 injury.

However, effective this date, the Board has reversed the Referee and concluded that the SAIF Corporation, as the insurer who had accepted the October, 1976 injury, is responsible. Elizabeth Coomer, 41 Van Natta 2300(Issued this date). Yet, inasmuch as claimant's aggravation rights under the October, 1976 injury claim had expired, the Board, in Coomer, supra, had jurisdiction to consider only the compensability of her current medical services. Here, under our Own Motion authority, we proceed to address the question of whether the claim should be reopened for the payment of temporary disability.

In accordance with ORS 656.278(1)(a), we may exercise our Own Motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. We found in Coomer, supra, that the October, 1976 injury materially contributed to claimant's current low back and right leg condition. The element of causation is, therefore, established.

Claimant has sustained a worsening of her compensable 1976 injury if she has experienced either a pathological or symptomatic exacerbation of her low back condition rendering her less able to work than at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). Alternatively, claimant has sustained a worsening if she has experienced a pathological or symptomatic exacerbation of her right leg condition resulting in increased loss of use or function since the last arrangement of compensation. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988).

The last arrangement of compensation was a May 1978 Determination Order closing the claim with an award of 10 percent unscheduled permanent disability for claimant's low back condition. We found in Coomer, supra, that claimant experienced gradually increasing low back and right leg pain following the May 1978 Determination Order. We further found that claimant's increased symptoms made it impossible for her to continue working after August 18, 1987. Accordingly, we conclude that claimant has sustained a symptomatic exacerbation resulting in diminished

earning capacity and further loss in right leg use or function since the last arrangement of compensation. Moreover, there is no persuasive evidence that the May 1988 Determination Order anticipated future exacerbations resulting in diminished earning capacity or further loss in right leg use or function. See Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989); Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (December 8, 1989). Claimant has, therefore, established a compensable worsening of her 1976 injury.

Accordingly, claimant's request for Own Motion reopening is granted. The October 1976 claim is reopened with temporary disability benefits to commence November 9, 1987, the date claimant was hospitalized for the required low back surgery. When appropriate, the 1976 injury claim should be closed by SAIF pursuant to OAR 438-12-055. SAIF shall continue paying temporary disability compensation until claimant is medically stationary and the claim is closed, or until claimant returns to regular work at the regular wage, whichever is earlier. As a reasonable attorney fee, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $1,050. OAR 438-15-080. 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.

RICHARD M. EGLI, Claimant — WCB 87-12189
Malagon & Moore, Claimant's Attorneys — December 12, 1989
Brian L. Pocock, Defense Attorney — Order on Review

Reviewed by Board Members Nichols and Crider.

The self-insured employer requests review of that portion of Referee Young's order that set aside its denial of claimant's occupational disease claim for a neck, low back, upper back and bilateral hip condition. Claimant cross-requests review of those portions of Referee Young's order that: (1) declined to assess a penalty and associated attorney fee for an alleged unreasonable denial; and (2) declined to award additional temporary disability compensation. We affirm in part and reverse in part.

ISSUES

1. Compensability.

2. Temporary Disability Benefits.

3. Penalties and Attorney Fees.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

FINDINGS OF ULTIMATE FACT

Claimant's work activities were the major cause of the onset of his right hip, upper back and neck conditions. Moreover, claimant's work activities were the major cause of a worsening of his preexisting low back and left hip conditions.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Board adopts the Referee's discussion regarding the compensability issue appearing on pages 5 through 6 of his order.

Temporary Disability

At issue on review is claimant's entitlement to temporary disability benefits between August 1986 and April 28, 1987. The Referee noted that, in WCB Case No. 87-00050, a prior referee had determined claimant to be retired and, therefore, not entitled to temporary disability compensation. The Referee concluded that principles of res judicata precluded him from redetermining claimant's entitlement to temporary disability during the period in question.

At issue in WCB Case No. 87-00050 was claimant's entitlement to temporary disability benefits beginning in late 1986 and resulting from his initial 1981 claim for his low back and left hip. The referee in WCB Case No. 87-00050 concluded that the claim had not been properly closed. Consequently, the claim was remanded to the employer for processing and proper closure. However, as noted above, the referee also concluded that claimant was not eligible for temporary disability benefits because he had retired from the work force.

Since issuance of the Referee's order below, the Board has issued its Order on Review in WCB Case No. 87-00050, where we held that claimant had not retired from the work force. Richard M. Egli, 41 Van Natta 149 (1989). We reversed the referee's refusal to award temporary disability benefits, and the claim was remanded to the employer for further processing. Our factual determination regarding the retirement issue was essential to our decision. Further, the issue has been finally determined in a case involving this employer. Consequently, we take official notice of the Order on Review in that case. Pursuant to principles of res judicata, our prior determination on this issue is accorded preclusive effect in this proceeding. See North Clackamas School District v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Therefore, we conclude that claimant is entitled to temporary disability benefits during the period in question.

As a result of our order in this case and in WCB Case No. 87-00050, claimant may currently have two open claims involving related conditions in the low back and left hip. Claimant is entitled to temporary disability benefits under both claims for some of the same periods. As relevant here, we find that claimant is entitled to temporary disability compensation until he is either medically stationary and has returned to work or the claim is closed. However, the employer is entitled to reduce the amount to be paid under this order by the amounts paid on WCB Case No. 87-00050. See Fischer v. SAIF, 76 Or App 656 (1985).

Penalties and Attorney Fees

The Board adopts the Referee's opinion on this issue.

ORDER

The Referee's order dated December 11, 1987 is affirmed in part and reversed in part. That portion of the Referee's order that declined to award temporary disability benefits is reversed. The claim is remanded to the self-insured employer for further processing in accordance with this order. Claimant's attorney is awarded an approved fee of 25 percent of claimant's increased temporary total disability compensation, not to exceed $3,800. This fee shall not be subject to any offset based upon prior overpayment of compensation. See OAR 438-15-085(2). This fee award is to be paid out of, not in addition to, claimant's increased compensation. The remainder of the Referee's order is affirmed. For prevailing on the employer's appeal of the compensability issue, claimant's attorney is awarded an assessed fee of $700, to be paid by the employer. The Board approves a client-paid fee, not to exceed $435.

KEITH E. GIBSON, Claimant	WCB 87-08515
Kilpatricks & Pope, Claimant's Attorneys	December 12, 1989
Davis & Bostwick, Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Wasley's order which: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled disability for a low back injury from 45 percent (144 degrees) to 60 percent (192 degrees). The insurer has submitted three motions for remand to consider newly discovered evidence. On review, the issues are remand and extent of permanent disability, including permanent total disability.

We affirm the Referee's order.

FINDINGS OF FACT

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

While pending Board review, the insurer has submitted three separate motions to "consider newly discovered evidence." Each motion has an attached medical report written several months after the close of the record.

CONCLUSIONS OF LAW AND OPINION

Remand

We may remand to the Referee for further evidence taking if we determine that this case has been "improperly, incompletely or otherwise insufficiently developed or heard by the referee." ORS 656.295(5). To warrant remand for the taking of additional evidence, it must be proven that such evidence was not obtainable at the time of the hearing with due diligence.

The insurer has submitted three motions for remand, seeking to have us consider medical reports developed after the hearing. In its Respondent's brief, the insurer sought to support the Referee's finding that claimant had not proven permanent total disability. It did not cross-request review seeking a reduction in the Referee's award of an additional 15 percent unscheduled

permanent disability. Inasmuch as we have affirmed the Referee's order based on the evidence available at hearing, there is no reason to consider additional evidence. We, therefore, decline to grant the insurer's motions.

Permanent Total Disability

To establish permanent total disability, claimant must prove that he is unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through medical evidence of physical incapacity or through the "odd-lot" doctrine under which a disabled person may be permanently disabled due to a combination of medical and nonmedical disabilities, which effectively foreclose him from gainful employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984).

At the hearing, surveillance films were admitted showing claimant involved in physical activities well beyond the capacities he displayed during his November 1987 Functional Capacities Assessment. The Referee found that claimant "has repeatedly exaggerated his physical ailments to [Dr. Weeks,] his treating physician" during the course of his claim. We agree.

Dr. Weeks is the only medical expert who supports the view that claimant is permanently totally disabled, yet, his opinion was based upon his understanding of claimant's physical capacities as claimant reported them to him. Inasmuch as we have found that claimant exaggerates the extent of his physical limitations and that his capacities, in fact, exceed those which he demonstrated to Dr. Weeks, we conclude that Weeks' opinion was based on an inaccurate history. His opinion is, therefore, not persuasive. Miller v. Granite Construction, 28 Or App 473 (1977). Moreover, we attach little probative weight to Weeks' pronouncements regarding claimant's vocational capacity. Although we recognize that Weeks can render such pronouncements, they are largely outside his area of expertise and are more reasonably within the expertise of qualified vocational experts.

The vocational opinion supporting the claim of permanent total disability was provided by Mr. Stinnett, vocational counselor. Stinnett relied on the opinion of Dr. Weeks, which we have found not persuasive. He also relied on the November, 1987, Functional Capacities Assessment. The author of the assessment, Ms. Young, physical therapist, testified that claimant's capacities appeared more limited in November, 1987, than those he displayed at the hearing and in the surveillance films. Accordingly, we are not persuaded by Stinnett's opinion.

In the opinion of the Orthopaedic Consultants, claimant's range of impairment was mildly moderate and he was capable of regularly performing sedentary work. Dr. Rosenbaum found claimant capable of sedentary work "even on a subjective basis." Mr. Rau, vocational counselor, testified that claimant had the capacity to be employed in a large variety of light and sedentary jobs. We are persuaded by the collective opinions of the Consultants, Rosenbaum and Rau. Claimant is able to regularly perform work of a light and sedentary nature. He is, therefore, not entitled to an award of permanent total disability.

Unscheduled Permanent Disability

We adopt the Referee's conclusions and reasoning on the issue of claimant's extent of unscheduled permanent disability.

ORDER

The Referee's order, dated June 28, 1988, is affirmed. The Board approves a client-paid fee, payable by the insurer to its counsel, not to exceed $1,504.50.

WENDY M. HABER, Claimant
Max Rae, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 86-07208
December 12, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Myers' order that upheld the SAIF Corporation's denial of her occupational disease claim for a stress-related psychological condition. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact section with the exception of the last 2 sentences of paragraph 7 and paragraph 10. We also make the following supplemental findings of fact.

Off work events and conditions did not significantly contribute to the development of claimant's mental illness.

On-the-job events and conditions reported by claimant can be divided into two categories: those which were real and those which were delusional. Real events included: (1) claimant's difficulty in balancing her cash drawer; (2) Jewish jokes told by co-workers in claimant's presence; (3) a poor monthly evaluation by claimant's supervisor; and (4) criticism of claimant by her supervisor in public. The balancing difficulties and poor evaluations in turn caused claimant to fear that she would be terminated from her position since she was employed as an MVR I on a trial basis only. In fact, she was told by her supervisor that she would be terminated from her MVR I position if she could not meet the balancing standard set in November 1985. (Tr. I, pp. 93, 95; Tr. II, pp. 197, 352, 358, 376).

Claimant's paranoid delusions were symptoms, not causes, of her illness. They revolved mainly around a perception, not based in reality, that co-workers were playing malicious pranks on her, including not putting film in the camera, mispronouncing her name, and incorrectly setting her date stamp. Other perceptions which had no basis in reality involved her belief that MVD personnel were following her and that her car and home were bugged.

The major cause of claimant's mental illness was the job stress produced by the following real events, in descending order of importance: (1) her balancing difficulties; (2) Jewish jokes; (3) poor work evaluations; and (4) criticism in public. Stressors 1, 3 and 4 combined to produce a more generalized fear of the possible loss of her job, which also resulted in stress and contributed to her mental illness.

CONCLUSIONS OF LAW

The Referee relied upon the law enunciated by the court in Elwood v. SAIF, 298 Or 429 (1985), in finding the claim not compensable. Based on Dr. Wight's testimony that the major stressor was claimant's actual fear of losing her job, he found the claim not compensable.

In order for her claim to be compensable, claimant must prove by a preponderance of the evidence that the real events and conditions of her employment, when viewed objectively, were capable of producing stress, and that they were in fact the major contributing cause of her psychiatric condition. McGarrah v. SAIF, 296 Or 145, 165-66 (1983).

Claimant succeeded in proving that real and stressful events and conditions existed in her employment. Those real events, however, were intricately intertwined with paranoid delusions, the symptoms of claimant's developing mental illness. In an attempt to unravel the real from the unreal, the parties presented two psychiatrists at hearing: Dr. Turco on behalf of the employer and Dr. Wight on behalf of claimant.

We defer to the opinion of Dr. Wight over that of Dr. Turco for a number of reasons. First, Dr. Wight was claimant's treating psychiatrist and had the unique perspective of knowing claimant both before and after the development of her mental illness. Although Dr. Turco examined claimant and sat through three days of hearing testimony, we are not persuaded that we should defer to his opinion over the well-reasoned and informed opinion of Dr. Wight. Second, Dr. Turco believed that the nature of claimant's work did not cause her to become psychotic because it would not have caused the average worker to become psychotic. (Tr. II, p. 476). We know, however, that the legal test is whether real events and conditions of claimant's employment are capable of producing stress when viewed "objectively", even though an average worker might not have responded adversely to them." Leary v. Pacific Northwest Bell, 67 Or App 766, 768 (1984). (Emphasis added). Therefore, Dr. Turco's medical opinion does not aid us in determining legal causation. Third, Dr. Turco admitted at hearing that he really did not know the cause of claimant's mental illness. (Tr. II, pp. 470, 476). Fourth, much of the history taken by Dr. Turco in formulating his medical opinion was not accurate, and those inaccuracies were correctly pointed out by Dr. Wight. (Tr. II, pp. 152-157).

Dr. Wight, on the other hand, persuasively distinguished between on-the-job events which were real and those which had no basis in reality. He based his opinion on his knowledge of claimant's condition as her treating psychiatrist. The credibility of his position was enhanced by the fact that, as the treating physician of her husband, Dr. Wight had the opportunity to know claimant long before her mental illness arose in the late fall of 1985. Accordingly, we defer to his opinion.

Dr. Wight opined that the stress caused by claimant's inability to balance the cash drawer was the ultimate stressor which caused her illness. (Tr. II, pp. 123, 142). In fact, Dr. Wight believed that

> "not being able to get the books balanced or the money balanced or whatever . . . was

> the major stressor [since it] was her impression that, you know -- that she would lose that job, and there would be no financial income at that point in time." (Tr. II, p. 142).

Dr. Wight also identified the Jewish/Nazi jokes told by claimant's co-workers in her presence, as well as her poor January work performance evaluation, as significant contributors to the development of her paranoia and ultimate mental illness. (Tr. II, pp. 124, 127, 134). By February 1986 claimant's paranoia had changed to incorporate beliefs of persecution. According to Dr. Wight, at that point in time claimant's thoughts had become very psychotic and out of touch with reality. He believed that her perceptions that DMV had bugged her home and car, that co-workers were tampering with the camera, her date stamp and documents, and that everyone at DMV was out to get rid of her, were delusional thoughts and had no basis in reality. (Tr. II, p. 129). Nonetheless, Dr. Wight believed that those events and conditions on the job which were in fact real were the major cause of her mental illness.

As noted above, Dr. Wight attributed the stress of claimant's inability to balance her cash drawer to her belief that a poor work performance would cause her to lose her job. SAIF offers two arguments in this regard in an attempt to defeat claimant's claim.

First, SAIF argues that, since nobody told claimant that she would be fired for poor work performance, the stress caused by her fear of discharge was not based on a real event. We have found, however, that claimant was informed that she would lose her MVR I position if she was not able to meet the cash drawer balancing standard set in November 1985. We believe that whether claimant thought that she would be demoted with a reduction in pay or terminated altogether is not a significant distinction. Either scenario is objectively capable of producing stress. Moreover, assuming arguendo that claimant had not even been informed that poor work performance would result in a demotion, we think that, when viewed "objectively," her poor work performance evaluation and difficulties balancing the cash drawer were real events in themselves which could cause claimant to fear that she would lose her job.

Next, SAIF argues that claimant's general fear of discharge is the major cause of her mental illness and therefore, according to the law in Elwood, supra, her claim is not compensable. We disagree.

In Elwood, the court distinguished between stress caused by the circumstances of employment and stress caused by the loss of a job. It stated that:

> "[t]he line, we think, runs between illness resulting from the stress of actual or anticipated unemployment, which is not compensable, and illness resulting from the circumstances and manner of discharge, which can be regarded as events still intrinsic to the employment relationship before termination and can lead to

compensation . . . The principle, however, is that stressful events accompanying the discharge can make a resulting illness compensable; illness resulting from the mere act of discharge and loss of the job is not." Id. at 433.

We believe that the Elwood decision speaks to a narrower set of circumstances, which do not encompass the present case. It applies to those situations where a claimant is or will be discharged. Here, claimant's stress was not the result of imminent discharge. Rather, her stress was related to the vague threat of a possible discharge due to poor work performance. That fact distinguishes her situation from the discharge-related stress addressed by the court in Elwood.

Assuming arguendo that we have drawn the law in Elwood too narrowly and it does in fact apply to the present case, we still find that claimant's fear of unemployment was not the major cause of her mental illness.

In Timothy R. Delp, 38 Van Natta 594 (1986), the Board applied the law as outlined in Elwood. In that case, claimant, a custodial employe of the Oregon State Hospital, was suspended without pay when he refused to pick up the soiled laundry of an AIDS patient. Id. at 595. As a result of this insubordination, claimant was terminated from his job; he subsequently filed a stress claim with the employer. Id. The Board held that had claimant's stress reaction resulted simply from being terminated from a job, his disorder would not be compensable. Id. at 596. The Board found from the record, however, that claimant's stress was a direct result of the circumstances leading to his discharge, i.e., his being ordered to handle a contagious patient's laundry. Id. Citing Elwood, supra at 433, the Board concluded that the events leading to claimant's discharge were intrinsic to the employment relationship before termination, and must be considered when determining the compensability of claimant's claim. Delp, supra.

The Delp analysis is helpful to us in reaching our decision. In the present case, claimant's stress reaction was a direct result of the circumstances leading to her fear of unemployment, i.e., her inability to balance the cash drawer and a poor work performance evaluation. Claimant would not have been afraid of the loss of her job in the absence of those circumstances. They were intrinsic to the employment relationship and must be considered when determining the compensability of her claim. The claim is compensable in light of Dr. Wight's opinion that the balancing problems, poor work performance evaluation, Nazi jokes and public criticism were the major cause of her mental illness.

ORDER

The Referee's order dated October 12, 1987 is reversed. 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 Board review, claimant's attorney is awarded a reasonable assessed fee of $14,800.

JOHN F. ROSS, Claimant
Black, Chapman & Webber, Claimant's Attorneys
Daryll E. Klein, Defense Attorney

WCB 87-03587 & 86-12704
December 12, 1989
Order on Review

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of that portion of Referee Galloway's order which found that he was not entitled to temporary disability benefits from July 11, 1986 through September 23, 1986. In its brief, the insurer contends that the Referee erred in upholding its July 11, 1986 partial denial of claimant's blackout spells since this denial had been previously set aside pursuant to a January 28, 1987 stipulation. On review, the issue is entitlement to temporary disability benefits. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to his neck and shoulders in August 1985 while working as a long haul truckdriver. His work required that he be available to drive 15 hours per day. Claimant was released for regular work as of September 9, 1985.

The claim was closed by a May 1986 Determination Order which awarded claimant temporary disability benefits only. In April 1986, claimant suffered a blackout episode and dizziness spell, which was diagnosed as post concussion syndrome. His attending chiropractor, Dr. Wehinger, authorized time loss on April 28, 1986.

In July 1986, the insurer denied this condition on the basis that it was not causally related to his original injury. By a January 1987 stipulation, the insurer withdrew this denial and accepted the condition. Following acceptance of the April 1986 claim, the insurer paid temporary disability benefits. The insurer did not pay temporary disability benefits for the period July 11, 1986 through September 23, 1986 on the basis of a July 1986 report from Dr. Campagna, neurologist, which released claimant for regular work.

Prior to this, in May 1986, Dr. Wehinger, claimant's treating chiropractor, had released claimant for modified work with the restriction that claimant work only 8 to 10 hours per day. Claimant reported these restrictions to the employer. However, the only employment available required claimant to work 15 hours per day. When apprised of this, Dr. Wehinger reported that claimant could not work beyond his stated restrictions. Claimant did not return to work with the employer. He accepted employment, as a long haul driver working 15 hours per day, with a different employer on September 23, 1986.

In a March 1987 denial letter the insurer reiterated that it was not responsible for wage loss on the basis of Dr. Campagna's July 1986 release to work.

FINDINGS OF ULTIMATE FACT

Claimant was not medically stationary on July 11, 1986.

Claimant had not been released to regular work on July 11, 1986 by his attending physician.

Claimant was disabled from performing his regular work between July 11, 1986 and September 23, 1986.

Claimant returned to regular work on September 23, 1986.

CONCLUSIONS OF LAW

At the outset, we agree with the parties that the Referee erred in upholding the July 11, 1986 partial denial. The parties had previously stipulated that the denial was rescinded. Accordingly, the aforementioned portion of the Referee's order is reversed. We now turn to the merits of the temporary disability benefits issue.

The Referee concluded that claimant was not entitled to temporary disability benefits from July 11, 1986 through September 23, 1986. The Referee reasoned that claimant had been found able to return to work without restrictions by his treating physician during this time period. We disagree.

ORS 656.268 requires temporary disability benefits to be paid until claimant is both released to work and medically stationary, or returns to regular work. See e.g. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 on recon, 93 Or App 103, rev den 307 Or 236 (1988). Unless the treating physician releases a claimant for return to the job he held at the time of his injury, a claimant has not been released to return to his regular work. Georgia Pacific v. Awmiller, 64 Or App 56, 60 (1983).

As a preliminary matter, an injured worker can have only one attending physician. ORS 656.005(13); OAR 436-10-060(2). Dr. Wehinger filled out the first medical treatment form in regard to claimant's original injury. He thereafter supplied supplemental reports on a continuous basis. There is no change of physician form in the record that would indicate that claimant had changed his attending physician. Accordingly, we find that Dr. Wehinger is claimant's attending physician within the meaning of ORS 656.005(13).

In May 1986, Dr. Wehinger released claimant to work, expressly conditioned on an 8 to 10 hour workday. The employer informed claimant that there was no work available within those restrictions. Dr. Wehinger then reported that since claimant's job situation required work beyond his restrictions, he would not be able to work for the employer at that time.

In light of these facts, we find that claimant was neither released for his regular work nor medically stationary between July 11, 1986 and September 23, 1986. Moreover, he was disabled from performing that regular work. Accordingly, he is entitled to temporary disability benefits during that time period.

ORDER

The Referee's order, dated November 10, 1987, is reversed. The insurer's July 11, 1986 denial is set aside in accordance with the January 28, 1987 stipulation. Claimant is awarded temporary disability benefits from July 11, 1986 through September 23, 1986. Claimant's counsel is awarded 25 percent of the increased compensation created by this award, not to exceed $3,000. A client-paid fee, not to exceed $208, is approved.

RITA L. SHEPHERD, Claimant
Quintin B. Estell, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 87-02557
December 12, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Brazeau's order which upheld the SAIF Corporation's denial of claimant's aggravation claim for a cervical-thoracic spine condition. We reverse.

ISSUE

Compensability of aggravation claim for cervical-thoracic spine condition.

FINDINGS OF FACT

Claimant, a psychiatric aide, compensably injured her neck, back and right shoulder on January 6, 1984. The diagnosis was cervical-thoracic strain and right shoulder strain. Claimant also had low back pain. She was released from work and treated conservatively. She has not worked for the employer since the injury.

The claim was accepted by SAIF and closed by Determination Order on June 18, 1984 with no permanent disability award. By stipulated agreement dated January 7, 1985, claimant was awarded 15 percent unscheduled permanent disability for the neck and right shoulder condition. We do not find that the stipulated agreement contemplated that claimant would experience future symptomatic flare-ups.

Claimant subsequently received vocational rehabilitation and, through her own efforts, secured a full-time bartending job in October, 1985. The lifting required in that job caused her back pain to increase. She left work after four months due to the increase in pain. She then worked as a supervisor in her mother's nursing home from July to December, 1986. No lifting was required in that job.

On November 7, 1986, claimant began treating with Dr. Taylor, a chiropractor, for headaches, dizziness, pain in the neck, middle back, right shoulder and arm, and loss of arm strength. Claimant also had myospasms from T5 through C6. Taylor restricted claimant from any type of lifting, particularly over shoulder level. At that time, claimant was capable of performing light work only.

Claimant improved with treatment and, by December 1, 1986, her condition had essentially stabilized and was nearing medically stationary status. At that time, she had some pain in the neck, upper back and low back. There were no spasms. Treatment was limited to the pelvis, T2, C6, upper trapezius, and splenius capitis.

On December 7, 1986, claimant was involved in an off-the-job auto accident. She subsequently saw Dr. Taylor with increased symptoms in her neck, upper back and low back.

Claimant filed a claim for aggravation of the compensable 1984 injury. SAIF denied that claim on February 6, 1987.

FINDINGS OF ULTIMATE FACT

Since the January 1985 stipulation, claimant has experienced a symptomatic exacerbation of her low back condition, resulting in diminished earning capacity. The compensable 1984 injury was a material contributing cause of that exacerbation.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant contended that she suffered a compensable aggravation following the January, 1985 stipulation, and she requested reopening of her claim as of November 7, 1986, the date she began treating with Dr. Taylor. The Referee disagreed, finding that claimant had not proven either a worsening of her condition or a causal relationship between the worsening and the compensable injury. We disagree with the Referee's findings and decision.

To establish a compensable aggravation, claimant must show: (1) a compensable worsening of her low back condition since the last arrangement of compensation by stipulation in January, 1985; and (2) a material relationship between the worsening and her compensable injury. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396 (1986).

Worsened Condition

In the context of an aggravation analysis, "worsening" means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Smith, supra. If the January, 1985 stipulation anticipated future symptomatic or pathological exacerbations, accompanied by a diminished earning capacity, claimant must also prove that: her earning capacity was diminished longer or in greater degree than was anticipated; or that her earning capacity was diminished to the extent of total disability, and resulted in 14 consecutive days of total disability or inpatient hospitalization. Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989); Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (December 8, 1989).

Claimant testified that her symptoms had increased since the January, 1985 stipulation. Her testimony was supported by Dr. Taylor, her treating chiropractor since November, 1986. Taylor reported that, during his initial examination, claimant was not medically stationary. She complained of pain in her neck, middle back, low back, right shoulder, arm and hand. She also had myospasms along her upper back. Based on x-rays and the examination, Taylor opined that her neck condition had deteriorated.

A contrary opinion was offered by Dr. Peterson, a chiropractor who conducted an independent medical examination (IME) on January 21, 1987. Peterson opined that there had been no material worsening of claimant's condition. However, we are most persuaded by Taylor's opinion. He was the only physician to examine claimant during the period of the alleged worsening in November, 1986. Moreover, as the treating physician, he had a better opportunity to evaluate her condition than did Peterson in his one-time IME. For that reason, his opinion is given greater weight. Weiland v. SAIF, 64 Or App 810, 814 (1983). Based on the testimonies of claimant and Dr. Taylor, we are persuaded that

claimant experienced an increase in symptoms after the last arrangement of compensation.

We are further persuaded that the increase in symptoms resulted in additional loss of claimant's ability to work in positions requiring lifting. She testified that she had been working as a bartender for four months, before worsening back pain forced her to quit. She testified that she was no longer able to perform the extensive lifting required, due to the worsening pain. Dr. Taylor testified that claimant was capable of light work only, with restrictions against any type of lifting. These limitations, though temporary and although not precluding her entirely from working, reduced claimant's ability to obtain and hold gainful employment in the broad field of general occupations, resulting in a loss of earning capacity. See ORS 656.214(5).

We turn to whether the January, 1985 stipulation anticipated future symptomatic or pathological exacerbations, accompanied by a diminished earning capacity. The language of the agreement itself is silent on that question. Moreover, aside from a Form 827 (First Medical Report) completed in January, 1984, the record is devoid of any medical evidence existing at the time of the January, 1985 stipulation. The Form 827 does not reflect any anticipation of future symptomatic flare-ups. We conclude that there is no evidence to support a finding that future symptomatic flare-ups were contemplated by the January, 1985 stipulation.

Because no symptomatic flare-ups were contemplated by the prior arrangement of compensation, any flare-up resulting in diminished earning capacity is at least a temporary worsening. Gwynn, supra. Accordingly, claimant has established a worsening of her low back condition since the last arrangement of compensation.

Causal Relationship

Claimant testified that her symptoms from the compensable injury persisted and eventually worsened after the stipulation. Dr. Taylor reported the increased symptoms and opined that the cervical condition had indeed deteriorated by November, 1986. Although Taylor opined that claimant's obesity was "the main aggravating factor of [her] industrial injury," it is clear from Taylor's testimony that the industrial injury itself remained a material contributing cause of the worsening symptoms. Moreover, there was no evidence of any intervening injury suffered between the time of the stipulation and Taylor's examination in November, 1986.

Contrary opinions were offered by Dr. Peterson and Dr. Bolin, a consulting chiropractor who examined claimant once in January, 1987. Bolin opined that claimant's low back pain was "almost totally related to obesity," while Peterson related the pain to obesity and "possible" degenerative disc disease at L5-S1. We are not persuaded by their opinions. First, we note that a mere possibility of disc disease is not enough to prove with reasonable certainty that such a condition actually exists. See Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981). Further, we found Dr. Taylor's opinion more persuasive for the same reasons discussed previously, i.e., his examinations were closer in time to the alleged worsening in November, 1986, and his status as treating physician gives his conclusions greater weight. For these reasons, we are satisfied that claimant has sustained her burden of proving that the compensable injury was a material contributing cause of her worsened condition.

Claimant has, therefore, established both the causation and the worsening elements of her aggravation claim. Accordingly, she has established a compensable aggravation of her 1984 injury.

Finally, claimant's counsel is entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review. ORS 656.386(1); OAR 438-15-055(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. OAR 438-15-010(5).

ORDER

The Referee's order dated September 28, 1987 is reversed. The SAIF Corporation's aggravation denial is set aside and the claim is remanded to SAIF for processing according to law.

FRANCES N. SIMS, Claimant	WCB 87-03028
Sellers & Jacobs, Claimant's Attorneys	December 12, 1989
Terrall & Miller, Defense Attorneys	Order on Review

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee McGeorge's order that: (1) set aside its denial of claimant's current medical services claim for a cervical condition; and (2) assessed a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are medical services, penalties, and attorney fees. We reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following ultimate finding of fact.

Claimant's 1979 compensable injury is a material contributing cause of her current need for medical treatment of her cervical condition.

CONCLUSIONS OF LAW AND OPINION

We adopt that portion of the Referee's "Opinion" which set aside the insurer's denial of claimant's medical services claim.

On the penalty and attorney fee issue, the Referee found the insurer's conduct in denying the medical services to be unreasonable, and assessed a penalty of 15 percent and an attorney fee of $300. The insurer argues that its conduct was not unreasonable, given the length of time between the 1980 closure of claimant's 1979 nondisabling injury claim and claimant's 1986 medical services claim, and the information available to it at the time of its denial. We agree.

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); ORS 656.382(1). 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); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985); Mt. Mazama Plywood Co. v. Beattie, 62 Or App 355, 358 (1983).

Here, claimant suffered a compensable cervical injury in 1979. She last submitted a medical services claim for this condition in 1980. The insurer did not receive another medical services claim until September, 1986. From the initial reports received, the insurer could have reasonably concluded that claimant was being treated for a new injury sustained when claimant stumbled on a sidewalk in September 1986. Therefore, we do not find that the insurer's initial denial was unreasonable.

Finally, in its brief on review, the insurer requests that we specifically address whether its denial is valid regarding a urinary spotting condition mentioned in certain medical reports. The record indicates that this issue was never raised at hearing, nor in the insurer's formal request for review. We therefore decline to address the issue.

Claimant's attorney is entitled to a fee for services on review concerning the compensability issue. See ORS 656.382(2). However, no fee has been awarded because no statement of services has been submitted. See OAR 438-15-010(5).

ORDER

The Referee's order dated December 8, 1987, is reversed in part. That portion which assessed a penalty and attorney fee for an unreasonable denial is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,153, is approved.

DELBERT W. SMITH, Claimant — WCB 86-15272
Max Rae, Claimant's Attorneys — December 12, 1989
Gary Wallmark (SAIF), Defense Attorney — Order on Review

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Howell's order that: (1) found that claimant's bilateral carpal tunnel syndrome claim was not prematurely closed; (2) affirmed a Determination Order award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right forearm; and (3) awarded a $25 insurer-paid attorney fee for services rendered in obtaining payment of prescribed vitamins and zinc. On review, the issues are premature claim closure, permanent disability, and attorney fees.

We affirm the order of the Referee with the following comment. In deciding the premature closure issue, the Referee stated: "The determination of claimant's medically stationary status is made based upon evidence available at the time of closure, not upon subsequent developments." We disagree with that statement of the law. The decisive inquiry is claimant's condition at the time of closure, without respect to subsequent changes in his condition. However, the Referee may consider evidence not available to the Evaluation Section at closure in determining claimant's condition at that time. Schuening v. J. R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987).

ORDER

The Referee's order dated August 5, 1987 is affirmed.

REID E. STOTTS, Claimant
Robert J. Thorbeck, Claimant's Attorney
Gail M. Gage (SAIF), Defense Attorney

WCB 87-18738
December 12, 1989
Order on Review

Reviewed by Board Members Brittingham and Nichols.

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

FINDINGS OF FACT

Claimant worked for SAIF's insured as a Leasing Counselor for subsidized housing. His work included interviewing prospective renters, enforcing lease rules, collecting rent and sometimes evicting tenants.

Because claimant fell behind in his job duties, such as housekeeping inspection, writing newsletters and scheduling meetings, his supervisor began to receive complaints from other agencies. After about 9 months, the supervisor began to send memos regarding claimant's job duties, and they subsequently met to discuss improving his job performance.

After providing notice that dismissal was under consideration, the employer held a pre-termination hearing in which it was determined that claimant had been insubordinate and inefficient and had failed to demonstrate sufficient diligence and attention to his duties. Claimant's eventual termination for cause was upheld.

After being notified of his termination, claimant became upset and unable to sleep. Claimant treated with Dr. Mead, psychiatrist. Dr. Mead released claimant from work for a ten day period, following which claimant filed a claim for mental stress arising out of his employment with SAIF's insured. In December, 1987, SAIF denied claimant's stress claim, stating that the condition was not related to his work with its insured.

ULTIMATE FINDING OF FACT

Claimant was not asked to violate rules or perform illegal acts as a condition of his employment. Real events at work were not the major contributing cause of claimant's stress-related condition.

CONCLUSIONS OF LAW

The Referee found claimant's stress claim was compensable due to the fact that work conditions were the major contributing cause of his mental stress condition. We disagree.

Claims for benefits arising out of stress-caused mental disorders are compensable if they flow from objectively existing conditions of the worker's employment and those work conditions, when compared to non-employment conditions, are the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145, 166 (1983). Claimant's reaction to the work events need not have been reasonable or rational. If claimant reacted to real events, he has a basis for a stress claim. See Leary v. Pacific Northwest Bell, 67 Or App 766 (1984).

The Referee concluded that claimant's inability to perform his job was real and led to memos and meetings with his supervisor and eventually to his termination. Noting that both doctors who had examined claimant had found that claimant's work was the major contributing cause of his stress condition, the Referee agreed and found the claim to be compensable.

SAIF contends that claimant's condition is not compensable, since his stress arose from fictional events, rather than real events or conditions of work. In Leary v. Pacific Northwest Bell, supra, a mental stress claim was found not compensable even though some of the stress-causing conditions were real and others were imagined.

SAIF argues that the majority of the factors found to have caused stress, such as a supervisor's instructions to illegally evict tenants, falsify documents and forge signatures, were fictional events. SAIF also points out that the Referee found that claimant's belief that he was being harassed or persecuted was a misperception.

The issue of whether claimant's work activities were the major cause of his stress condition is a complex medical question. Thus, although claimant's testimony is probative, resolution of the issue turns largely on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Both Dr. Mead, the treating doctor, and Dr. Turco, the independent medical examiner, found claimant's job to be the major cause of his disabling condition. However, Dr. Mead found that the element of claimant's employment that caused him the most stress was the fact that he felt that he was directed to perform unlawful activities. Dr. Turco also noted claimant's statement that the "largest part of the stress" at work was the requirement that he lie and falsify documents. Dr. Turco concluded that claimant had experienced an adjustment disorder related to the circumstances at his place of employment, particularly in the context of a disagreement he had with his former employer as well as problems associated with what he felt was dishonesty.

Having found that claimant was not asked to perform illegal acts in the course of his employment, we conclude that both Dr. Mead and Dr. Turco relied on unreal perceptions related to them by claimant. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (Medical opinions based on inaccurate histories are not persuasive). Under the circumstances, we therefore find neither doctor's opinion to be persuasive in supporting claimant's contention that employment conditions were the major contributing cause of his mental stress condition.

Finally, we note that our review of this record indicates that claimant's complaints did not arise until after he received notice in September that he was to be terminated and requested a pre-termination hearing. When claimant first saw Dr. Mead, he complained of being angry and worried, having a disturbed appetite, and not being able to sleep for three days after receiving notice of the hearing. In Elwood v. SAIF, 298 Or 429 (1984), the Court held that illness resulting from the stress of actual or anticipated unemployment is not compensable. However, neither of the doctors who examined claimant commented on the effect of such stress upon claimant's condition, therefore, it is not a consideration in our decision.

ORDER

The Referee's order, dated April 29, 1988, is reversed. The SAIF Corporation's denial is reinstated and upheld.

TIMOTHY E. DOOLEY, Claimant
Gary K. Jensen, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-89026
December 13, 1989
Third Party Distribution Order

The SAIF Corporation, 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, the dispute concerns SAIF's assertion that it is a paying agency and, as such, is entitled to a share of the settlement proceeds resulting from claimant' cause of action for negligence stemming from a motor vehicle accident, which occurred while claimant's compensable injury claim remained in open status. We conclude that SAIF is not entitled to a "third party" lien from the settlement proceeds.

FINDINGS OF FACT

In June 1986 claimant sustained a compensable back injury. He experienced primarily low back and left hip pain, but also had complaints in and about his neck and interscapular region. Treatment was conservative, consisting of chiropractic modalities and pain center sessions.

Claimant's compensable condition was nearing a medically stationary status when, in May 1987, he was involved in an off-the-job motor vehicle accident with another vehicle. As a result of this accident, his low back, left hip, and neck complaints increased.

Claimant's compensable injury claim was eventually closed by a May 1988 Determination Order. Claimant was awarded temporary disability from November 1986 through April 1988. In addition, he was granted 10 percent unscheduled permanent disability resulting from his compensable back injury. Claimant requested a hearing concerning the Determination Order. However, claimant subsequently withdrew his hearing request, prompting a September 1988 Dismissal Order.

Claimant's treating physician was able to differentiate the medical bills attributable to the motor vehicle accident from those related to the compensable injury. Consequently, SAIF was not billed for medical expenses resulting from the motor vehicle accident. However, because of the accident, claimant suffered an additional three to four months of temporary disability which he would not otherwise have incurred. SAIF provided temporary disability compensation for this additional period.

Claimant engaged legal counsel to explore the possibility of bringing suit against the driver of the other motor vehicle. Thereafter, a civil action for negligence was initiated against the other driver.

With SAIF's approval, claimant and the other driver settled the cause of action for $24,593.75. SAIF asserts a "third party" lien against the remaining proceeds from this settlement. The lien is composed of $5,481.43, which constitutes some four

months of temporary disability compensation. Claimant does not contest the fact that the aforementioned amount represents four months of temporary disability benefits. Instead, he contends that the settlement proceeds are not subject to a "third party" lien.

ULTIMATE FINDINGS OF FACT

As a result of the May 1987 motor vehicle accident, claimant did not receive a compensable injury due to the negligence or wrong of a third person.

CONCLUSIONS OF LAW

If an injury to a worker is due to the negligence or wrong of a third person not in the same employ, the injured worker may elect to seek a remedy against the third person. ORS 656.154. 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, the worker shall elect whether to recover damages from such third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593.

Despite the existence of a noncompensable intervening injury, an insurer remains responsible for benefits so long as the compensable injury remains a material contributing cause of the worker's disability and need for medical treatment. Grable v. Weyerhaeuser Co., 291 Or 387 (1981). Furthermore, the consequences of treatment for a compensable injury or disease are themselves compensable. Williams v. Gates, McDonald & Co., 300 Or 278 (1985).

Claimant argues that he did not sustain a "compensable injury due to the negligence or wrong of a third person." See ORS 656.578. Therefore, he contends that his cause of action against the driver of the other vehicle was not subject to ORS 656.576 et seq and SAIF is not entitled to a share of the settlement proceeds. We agree.

As previously noted, the proceeds of any damages recovered from a third person are subject to an insurer's lien as paying agency, provided that the worker has received a compensable injury due to the negligence or wrong of the third person. ORS 656.154; 656.578; 656.593. Here, no contention has been made that the motor vehicle accident was compensable. Similarly, there is no assertion that the accident was a consequence of claimant's compensable injury. Consequently, we conclude that any damages resulting from this accident are not subject to the "third party recovery" statutes.

SAIF asserts that it remained responsible for claimant's disability despite the motor vehicle accident. Since the effects of the accident caused it to pay additional temporary disability benefits it would not have otherwise incurred, SAIF submits it is entitled to recover such costs from the settlement.

SAIF bases its contentions on the following medical evidence. Dr. Schachner, claimant's treating orthopedist, and Dr. Russell, his attending chiropractor, have opined that the subsequent motor vehicle accident worsened claimant's compensable condition. Dr. Schachner further concluded that the motor vehicle

accident "probably added a good three to four months of additional disability before bringing the entire picture back to premotor vehicle accident level." Dr. Russell agreed that claimant's condition stemmed from the compensable injury, which had in all probability been complicated and worsened" by the motor vehicle accident.

We concur with SAIF's assessment that it remains responsible for any treatment or disability for which the compensable injury remains a material contributing factor. Grable, supra. However, this conclusion does not mean that SAIF is entitled to a share of settlement proceeds which stem from an accident which is neither compensable in its own right nor as a consequence of a compensable injury.

In conclusion, the record establishes that SAIF provided $5,481.43 in workers' compensation benefits that were solely related to the motor vehicle accident. Yet, because this accident was neither a compensable injury nor the consequence of a compensable injury, SAIF is not entitled to a share of the settlement proceeds resulting from the accident. See ORS 656.154; 656.578.

Accordingly, we hold that the SAIF Corporation is not entitled to a "third party" lien from the settlement proceeds. Claimant's attorney may disburse the remaining proceeds unencumbered by the statutory provisions of ORS 656.593.

IT IS SO ORDERED.

STEPHANIE A. GEE, Claimant
Roll & Westmoreland, Claimant's Attorneys
Roberts, et al., Defense Attorneys
David C. Force, Attorney

WCB 89-09625
December 13, 1989
Order Denying Motion to Intervene

Dr. Buttler, claimant's attending chiropractor, moves the Board for an order permitting him to intervene as a party to these proceedings. The motion is denied.

FINDINGS OF FACT

The Referee's order issued on October 11, 1989. Pursuant to the Referee's order, the self-insured employer's denial of claimant's medical services claim for treatments provided by Dr. Buttler to the date of the denial was upheld. Claimant requested Board review within 30 days of the Referee's order.

CONCLUSIONS OF LAW

Contending that claimant's interests are not "congruent" with his own, Dr. Buttler asks to be allowed to intervene in this proceeding as a "party." Specifically, Dr. Buttler seeks permission to submit a brief on review contending that ORS 656.327 provides the exclusive remedy from which an employer can dispute the compensability of a medical services claim.

To begin, jurisdictional questions are considered regardless of whether the issue has been raised or argued on review. Thus, we disagree with Dr. Buttler's assertion that he must be allowed to intervene to insure that the jurisdictional issue will be advanced.

In any event, "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(19). An attending physician is not a party. See Karen K. Van Santen, 40 Van Natta 63 (1988).

Based on the foregoing reasoning, Dr. Buttler's motion for intervention is denied. We retain jurisdiction over this matter. Consequently, this order is interim and will be incorporated into our final, appealable order. The parties' briefing schedule shall continue as previously implemented.

IT IS SO ORDERED.

JAMES F. HILL, Claimant — WCB 87-05861
Francesconi & Associates, Claimant's Attorneys — December 13, 1989
Williams, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Perry and Howell.

The insurer requests review of that portion of Referee Hettle's order that set aside its partial denial of claimant's chiropractic treatment in excess of the administrative guidelines. On review, the sole issue is entitlement to chiropractic treatment beyond the guidelines. We reverse.

FINDINGS OF FACT

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

Claimant's chiropractic treatments in excess of two times per month were not reasonable and necessary medical services.

CONCLUSIONS OF LAW

The Referee found that the medical reports of Drs. Stellflug and Knox, combined with claimant's credible testimony, demonstrated that the additional chiropractic treatment was reasonable and necessary. We disagree.

A claimant is entitled to all reasonable and necessary curative or palliative medical care required for recovery from a compensable injury or for relief of pain. See ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); Wetzel v. Goodwin Bros., 50 Or App 101 (1981); McGarry v. SAIF, 24 Or App 883, 888 (1976). For example, palliative chiropractic treatment, on an as-needed basis, is compensable where it is necessary to relieve severe pain and permit claimant to work. West v. SAIF, supra at 320-21. Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

In determining what is reasonable and necessary, the Board may consider the frequency of treatment. James v. Kemper Ins. Co., 81 Or App 80 (1986); Stephen C. Marr, 38 Van Natta 1304 (1986). Guidelines issued by the Workers' Compensation Division identify two visits per month, after the initial 60 days, as the usual frequency of medical services. OAR 436-10-040(2)(a). However, a claimant is entitled to treatment in excess of the administrative guidelines if he or she proves that the treatment is necessary due to the nature of the injury or to the process of

recovery. James v. Kemper, supra at 82-84; West v. SAIF, supra at 320; Kemp v. Worker's Comp. Dept., 65 Or App 659, 669 (1983), modified, 67 Or App 270, rev den 297 Or 227 (1984).

Although the Board generally gives greater weight to the conclusions of a treating physician, 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).

As a result of his compensable injury, claimant suffered from intermittent low back and leg pain; there were times, however, when he was symptom free. Dr. Stellflug treated him twice a week for that low back and leg pain. Claimant testified that the treatments helped to decrease the pain; he felt that the palliative effects lasted three or four days. Since claimant was not working at the time, however, the treatments did not increase his ability to stay on any particular job. Likewise, no evidence was presented to establish that chiropractic treatments enabled claimant to attend college classes.

Dr. Stellflug did not comment on the reasonableness and necessity of chiropractic treatments in excess of two times per month. Neither did Dr. Knox. Dr. Stellflug only stated that: (1) claimant's type of low back problem was notorious for slow recovery (ex. 28); (2) claimant's clinical findings explained the treatment he had been receiving (ex. 40); and (3) claimant was responding to conservative care (ex. 41). Similarly, Dr. Knox' opinion that claimant was suffering from an apparent irritative L5-S1 radiculopathy, more prominent on the left than on the right, did not address the appropriateness of chiropractic treatment.

On the other hand, the Western Medical Consultants examined claimant in May 1987 and found that the results of that examination were "consistent with very little ongoing problems" and felt that he had received maximum improvement from his injury. They recommended that claimant's chiropractic treatments be discontinued and that his claim be closed with no permanent partial impairment. They recommended against any further treatment, noting claimant's tendency to be dependent upon his chiropractor.

Further, claimant's testimony in regard to his severe pain symptoms is not supported by the medical evidence. Western Medical Consultants noted interference and inconsistencies with the sensory examination. Dr. Wilson reported that claimant's subjective complaints far outweighed any objective findings. Accordingly, to the extent that claimant's testimony does not comport with the medical evidence, we do not rely on it.

In conclusion, we find no medical evidence to support continued chiropractic treatments in excess of the administrative guidelines. Further, we find that claimant's testimony in regard to pain symptoms, to be exaggerated and do not accord it any weight. Therefore, we conclude that claimant has not established that his chiropractic treatments in excess of two times per month were reasonable and necessary medical services.

ORDER

The Referee's order dated November 17, 1987 is reversed in part. That portion of the order that set aside the insurer's

partial denial of chiropractic treatments in excess of the administrative guidelines and awarded an assessed attorney fee is reversed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $703.

RONALD K. HOBBS, Claimant
James K. Gardner, Claimant's Attorney
David O. Horne, Defense Attorney

WCB 86-08811
December 13, 1989
Order on Review

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of that portions of Referee Tuhy's order that upheld the insurer's medical services denials of his March, 1987, low back surgery. The insurer cross-requests review of that portion of the Referee's order that set aside its aggravation denial. In addition, the insurer requests that -- should the Board reverse on the aggravation issue and reinstate its denial -- that we remand to the Referee on the issue of the extent of claimant's unscheduled permanent disability. In this event, claimant requests that the Board rate claimant's unscheduled permanent disability, and that his award should be greater than that projected by his two previous Determination Orders.

We affirm on the medical services issue, but reverse on the issue of aggravation.

ISSUES

1. Whether claimant's low back surgery of March, 1987, was reasonable and necessary treatment materially related to his March, 1984, compensable injury.

2. Whether claimant sustained an aggravation of his March, 1984, compensable injury.

3. Whether claimant is entitled to an additional award of unscheduled permanent disability for his back condition.

FINDINGS OF FACT

Claimant has sustained three compensable injuries to his low back: the first, in July, 1975; the second, in February, 1979; and the last, in March, 1984. The July, 1975, injury occurred while claimant was working for a former employer, who is not a party in this proceeding. The latter two injuries occurred while claimant was working for the instant insured.

Shortly after claimant's March, 1984, injury, he was hospitalized for complaints of low back pain. He was examined by Dr. Berkeley, a neurosurgeon. Berkeley diagnosed sciatica and a lateral recess syndrome. On March 26, 1984, claimant underwent L4-5 decompression surgery performed by Berkeley. As a result, his sciatica subsided. He continued, however, to experience muscle spasms in his calves. In July, 1984, his sciatica resurfaced following a twisting incident. He returned to Berkeley. After a period of unsuccessful conservative treatment, Berkeley recommended further low back surgery.

In August, 1984, claimant was examined by the Orthopaedic Consultants. The Consultants found moderate to severe functional overlay and recommended against further surgery.

A few months later, claimant was seen by Dr. Thompson, an orthopedic surgeon. Although Thompson found less functional interference than the Consultants, he agreed that further surgery was not indicated.

In November, 1984, claimant was evaluated by a panel of physicians at a pain center. The panel, including a psychologist, concluded that claimant's main problems were psychological and that further surgery was contraindicated.

A Determination Order issued in October, 1985, awarding a period of temporary disability and 20 percent unscheduled permanent disability. Shortly thereafter, claimant began a course in restaurant management through a vocational rehabilitation program. A second Determination Order issued in October, 1986, awarding further temporary disability and an additional 5 percent unscheduled permanent disability.

In December, 1986, claimant consulted Dr. Nash, his current treating physician. X-rays and an MRI revealed: (1) mild disc narrowing at L4-5 and L5-S1; (2) degenerative disc disease at L3-4 and L4-5; and (3) foraminal stenosis at L4-5. As a result of those findings, Nash hospitalized claimant on January 7, 1987, and requested the insurer's authorization to perform further low back surgery. Thompson reexamined claimant while he was hospitalized and found no signs of a ruptured disc at L4-5. According to Thompson, further surgery was not warranted, but, if it was, it should take place at L3-4. Claimant was discharged from the hospital on January 16, 1987, after the insurer declined to authorize Nash's request for further surgery.

On January 30, 1987, the insurer issued a denial of further low back surgery. A second denial followed, on February 24, 1987, denying an aggravation.

In March, 1987, Nash rehospitalized claimant and performed the unauthorized surgery at L4-5. After 10 days of hospitalization, claimant was discharged.

In July, 1987, the insurer issued a third denial, which clarified that it had denied claimant's low back surgery of March, 1987.

ULTIMATE FINDINGS OF FACT

The additional low back surgery performed by Nash in March, 1987, was not reasonable and necessary medical treatment.

Claimant's has not experienced a symptomatic or pathological exacerbation, resulting in diminished earning capacity since the last arrangement of compensation in October, 1986.

Claimant's permanent loss of earning capacity does not exceed the 25 percent previously awarded by the October, 1985, and October, 1986, Determination Orders.

CONCLUSIONS OF LAW

Medical Services

We adopt that portion of the Referee's opinion

pertaining to the issue of the compensability of claimant's March, 1987, surgery.

Aggravation

To establish an aggravation, claimant must show a compensable worsening of his low back condition since the last arrangement of compensation by Determination Order issued October, 1986. Smith v. SAIF, 302 Or 396 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. If the October, 1986 Determination Order anticipated future symptomatic or pathological exacerbations, accompanied by a diminished earning capacity, claimant must also prove: (1) that his earning capacity was diminished longer or in greater degree than was anticipated; or (2) that his earning capacity was diminished to the extent of total disability, and resulted in 14 consecutive days of total disability or inpatient hospitalization. Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988)

Finding that claimant had been hospitalized and, according to treating physician Nash, totally incapacitated for more than 14 days, the Referee concluded that claimant had established an aggravation as a matter of law. We disagree with with Referee's conclusion. The Referee failed to apply the first part of the aggravation analysis set forth above. That is, he did not first determine whether claimant experienced a symptomatic or pathological exacerbation, resulting in a diminishment of earning capacity, since the October, 1986 Determination Order. Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989); Edward D. Lucas, 41 Van Natta 2272 (December 8, 1989). We conclude that claimant has not carried his burden of proof on this element of the aggravation analysis.

Claimant was hospitalized on two different occasions by treating physician Nash: 10 days in January, 1987, and 11 days in March, 1987. After the insurer issued its medical services denial of January 30, 1987, claimant was discharged from the hospital. Notwithstanding the insurer's denial, Nash proceeded with the surgery in March, 1987. Nash hospitalized claimant, at least in part, for the purpose of performing further low back surgery. We have found above, however, that the further surgery requested by Nash was not reasonable and necessary medical treatment.

The only medical expert supporting the view that claimant suffered a worsened condition is Nash. In January, 1987, Nash opined: "[Claimant] has been unable to be actively employed since December 10, 1986." Generally, we assign greater weight to the opinion of a claimant's treating physician. Weiland v. SAIF, 63 Or App 810 (1983). In this case, however, we find persuasive reasons not to do so.

First, Dr. Nash did not observe claimant until December 10, 1986. He, therefore, did not have an opportunity to personally observe claimant's condition prior to the October, 1986, Determination Order and to, then, make a comparison based on firsthand knowledge. See Kienow Food Stores v. Lyster, 79 Or App 416 (1986).

Second, Dr. Nash had an inaccurate history of claimant's low back condition. In his report of December 10, 1986, he stated, inter alia:

"Following the second surgery [of February, 1979] the [claimant's] complaints resolved.

"The [claimant] was then without complaint until March 1, 1984. On that date while in the course of his employment . . . he . . . tripped over a hole falling in a twisting motion to the right terminating any prat-type-fall." (Emphasis added).

In fact, however, claimant continued to experience low back pain following his surgery of February, 1979. Dr. Pasquesi, an orthopedic surgeon, examined claimant in December, 1979, and noted complaints of mid-to-low back pain. In May, 1980, claimant was examined by Dr. Rosenbaum, his former treating physician, for complaints of recurrent back pain and sciatica. Rosenbaum reexamined claimant in April, 1981. A myelogram performed at that time revealed either residual or recurrent disc disease at L4-5. Shortly thereafter, claimant underwent a lumbar laminectomy performed by Rosenbaum. Although he was released back to work in September, 1981, Rosenbaum limited his lifting activities.

In contrast to Dr. Nash, Dr. Thompson personally examined claimant both before and after the critical date of October, 1986. See Kienow Food Stores, supra. He, therefore, was in the best position to evaluate whether claimant's condition had worsened. After comparing his examination findings of 1984, 1985, and 1987, Thompson opined that claimant's condition had not changed. Moreover, unlike Nash, we find little evidence that Thompson had an inaccurate history of claimant's medical condition between 1979 and 1984.

In sum, we are persuaded by the opinion of Dr. Thompson, over that of Dr. Nash. Somers v. SAIF, 77 Or App 259, 263 (1986). We, therefore, conclude that, despite claimant's brief periods of hospitalization in January and March, 1987, he has not experienced a symptomatic or pathological exacerbation of his low back condition, resulting in diminished earning capacity, since the October, 1986 Determination Order. Accordingly, claimant has not demonstrated a compensable aggravation claim.

Extent of Unscheduled Permanent Disability

a. Remand

The insurer seeks remand on this issue. We may remand when the record is incompletely, inappropriately, or otherwise insufficiently developed. ORS 656.295(5). Here, claimant raised the issue of the extent of his unscheduled disability as an alternative issue. He introduced evidence on that issue by way of both documentary exhibits and his testimony. Under such circumstances, we conclude that the record has been adequately developed and we decline to remand. See Bryan W. Johnston, 40 Van Natta 58 (1988).

b. Merits

The test for awarding unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining loss of earning capacity, we consider the worker's physical impairment and all of the

relevant social and vocational guidelines set forth in former OAR 436-30-380 et seq. Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Here, claimant is relatively young at 40 years of age. Although he dropped out of school after completing the eighth grade, he apparently completed the requirements for a GED certificate while serving in the Navy. He has also partially completed vocational training courses in restaurant management. The bulk of his work experience, however, consists of truck driving, which he presently is unable to perform due to the permanent residuals of his March, 1984, injury. In July, 1985, Berkeley recommended that claimant avoid prolonged sitting or standing, but did not similarly restrict his ability to walk. Berkeley assessed claimant's permanent physical impairment as mild to moderate and restricted him from repetitively lifting in excess of 25 to 30 pounds. At the hearing, however, claimant testified that his ability to walk and stand was "very much improved." He regularly walks "over two miles a day." Monday through Saturday he tends to "a family owned and operated restaurant."

Considering claimant's relatively young age, his training in the lighter field of restaurant management, his improved ability to walk and stand, and his regular performance of work at his family owned restaurant, we conclude that his award of 25 percent unscheduled permanent disability appropriately compensates him for his permanent loss of earning capacity.

ORDER

The Referee's order, dated January 19, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that set aside the insurer's aggravation denial and awarded an attorney fee is reversed. The insurer's aggravation denial is upheld and reinstated. All remaining portions of the Referee's order, save for that portion which declined to address the issue of unscheduled permanent disability, are affirmed. The Determination Orders are affirmed.

WILLIAM G. MATTISON, Claimant	WCB 87-16449
Craine & Love, Claimant's Attorneys	December 13, 1989
Garrett, et al., Defense Attorneys	Order on Review (Remanding)

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of those portions of Referee Howell's order that: (1) admitted certain hospital records into evidence even though such records were neither disclosed or submitted by claimant until the day of the hearing; and (2) declined the employer's requests for postponement and continuance to allow it time to submit additional evidence. The employer has also filed motions with the Board for remand to the Referee for consideration of additional evidence. These motions have been consolidated with the employer's request for review.

On review, the issues are:

1. Whether the Referee abused his discretion in admitting evidence that was not exchanged prior to hearing.

2. Whether the Referee abused his discretion in

declining to grant the employer's motions for postponement and continuance.

3. Whether the case should be remanded to the Referee for further proceedings.

We vacate the Referee's order and remand to the Hearings Division for further proceedings.

FINDINGS OF FACT

Claimant has worked as a fire fighter for the employer since January 27, 1975. On August 3, 1987, he filed a claim for a myocardial infarction occurring on July 28, 1987. The claim included a statement from claimant's supervisor that claimant had experienced a myocardial infarction on that date and was admitted to the hospital.

The claim was processed by Mr. Johnson, assistant manager for the employer's processing agent. He contacted the admitting hospital listed on the claim form within a few days of receiving the claim. He was informed that claimant was not a patient in the hospital's cardiac unit and that it had no treatment records regarding claimant's myocardial infarction. On October 14, 1987, the employer's processing agent issued a formal denial of the claim on the grounds that it had received no medical evidence demonstrating that claimant's myocardial infarction was work-related. On at least two subsequent occasions, the claims examiner orally requested copies of relevant medical records from the law firm representing claimant. Each time, he was informed that the firm had no medical records in its files. The claims examiner made no further efforts to obtain medical records.

A hearing on the employer's denial was requested and held on January 8, 1988. Two weeks before the hearing, the employer's attorney phoned claimant's counsel to determine whether claimant wished to proceed with the hearing. Claimant's counsel did not return the call and did not speak with the employer's attorney until the day before the hearing. At that time, claimant's counsel again told the employer's attorney that she had no medical evidence relevant to the claim. The employer's attorney then informed claimant's counsel that he would argue that claimant could not demonstrate that he had experienced a myocardial infarction without supporting medical documentation.

On the morning of the hearing, claimant's counsel procured medical records from the admitting hospital and offered them at hearing. This was the employer's first knowledge of the existence of medical records documenting claimant's myocardial infarction. The Referee admitted the medical records over the employer's objection. The employer then requested a postponement to allow it time to obtain rebuttal evidence, and the Referee denied its request. The employer subsequently filed a motion for reconsideration of the Referee's evidentiary ruling. In the alternative, it requested a continuance to allow it time to respond to the medical records submitted by claimant. The Referee adhered to his prior evidentiary ruling and refused to grant a continuance. The employer requested Board review and also filed motions for remand to the Referee for consideration of additional evidence.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

The Referee admitted the hospital records at issue in this case because claimant had complied with former OAR 438-07-015(4). Under that provision, documents acquired by a party after an initial exchange of claims information had to be disclosed within seven days of receipt. On review, the employer contends that the hospital records were "exhibits" under former OAR 438-07-018, rather than "claims information" under former OAR 438-07-015. According to the employer, former OAR 438-07-018(2) required claimant to disclose all proposed exhibits at least ten days before hearing. The employer contends that exhibits disclosed after that time were admissible only at the Referee's discretion, pursuant to former OAR 438-07-015(6). It further contends that the Referee's admission of the records in this case was an abuse of that discretion.

We disagree. The Referee's discretion to admit or exclude evidence was limited to documents "not disclosed as required by [the] rules." See former OAR 438-07-015(6). The hospital records at issue in this case were properly disclosed under the rules. Contrary to the employer's assertion, former OAR 438-07-018(2) did not require disclosure of all exhibits at least 10 days prior to hearing. It merely required the parties to disclose exhibits then in their possession at least ten days prior to hearing. Additional exhibits obtained after that time were admissible if submitted "before the hearing." See former OAR 438-07-018(3). Here, claimant submitted the hospital records at issue immediately prior to the hearing. Moreover, she disclosed those records within 7 days of receipt, as required by OAR 438-07-015(4). Accordingly, the Referee correctly admitted the records into evidence and did not have discretion to exclude them. We affirm his evidentiary ruling.

Requests for Postponement/Continuance/Remand

Under the rules in effect at the time of the hearing, the Referee had express authority to postpone the hearing upon a finding of "extraordinary circumstances" beyond the control of the employer. See former OAR 438-06-081. Such circumstances did not include incomplete case preparation, unless the referee found that completion of the record could not be accomplished with "due diligence." See former OAR 438-06-081(4). The rules also expressly authorized the Referee to grant a continuance for any reason that would justify postponement, or "upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence . . ." See OAR 438-06-091(3) and (4). However, the Referee was not bound by technical or formal rules of procedure, and he had statutory authority to conduct the hearing in any manner that would achieve "substantial justice." See ORS 656.283(7).

The Referee found that the employer could have obtained the medical records in question well before the hearing if it had exercised due diligence in its claims investigation. Accordingly, he concluded that the employer was not entitled to either a postponement or a continuance. On review, the employer contends that the Referee abused his discretion in not granting his request

for a postponement or a continuance. In the alternative, it contends that the Referee's ruling violated its constitutional right to due process and a full and fair hearing.

As a preliminary matter, we note that the present case was litigated pursuant to the "fireman's presumption" created by former ORS 656.802. Under that provision, a compensable work-related condition was presumed if a claimant demonstrated a number of threshold elements, including proof that a condition was attributable to myocardial infarction or some other heart disease. Once the presumption was established, the burden of proof passed to the employer to rebut the presumption by "clear and convincing evidence." In the present case, medical evidence was necessary to demonstrate that claimant has suffered a myocardial infarction or some other heart disease. Absent such evidence, the employer had no reason to obtain additional medical records because the presumption would not apply.

We are persuaded that the disclosure of claimant's hospital records on the morning of the hearing was the employer's first knowledge of medical documentation of a myocardial infarction. We are further persuaded that the employer used due diligence in determining whether claimant intended to offer such evidence at hearing. The responsible claims examiner contacted the admitting hospital identified on the claim form and was incorrectly informed that claimant had not been treated for a heart condition at that institution. The claims examiner also spoke with attorneys at the law firm representing claimant on at least two occasions, and they assured him they had no medical information regarding the claim. The employer's attorney also attempted to contact claimant's counsel about this matter two weeks before hearing, but his phone call was not returned. Claimant's counsel finally talked with the employer's attorney the day before the hearing and, again, informed him that she had no medical evidence relevant to the claim.

Under these circumstances, we are persuaded that the employer exercised due diligence in preparing this case. See former OAR 438-06-081(4) and OAR 438-06-091(3) and (4). We are further persuaded that "substantial justice" will not be served unless the employer is given an opportunity to obtain and submit additional evidence rebutting the medical evidence disclosed and submitted by claimant on the day of the hearing. See ORS 656.283(7). We, therefore, conclude that the Referee's refusal to grant the employer a postponement or continuance resulted in an insufficiently developed record. See ORS 656.295(5). Accordingly, this matter is remanded to the Referee for further proceedings.

ORDER

The Referee's order is vacated, and the matter is remanded to the Presiding Referee with instructions to assign this case to another Referee. The employer is allowed an opportunity to obtain and submit additional testimonial or documentary evidence to rebut the medical evidence disclosed and submitted by claimant on the day of the hearing. Claimant's attorney should then be given an opportunity to present testimonial or documentary rebuttal evidence. After this additional evidence has been submitted, the Referee shall issue a final, appealable, Order on Remand reconsidering the claim in light of the additional evidence. The Board approves a client-paid fee, not to exceed $3,917.

IT IS SO ORDERED.

GAIL McKINNEY, Claimant
Velure & Yates, Claimant's Attorneys
H. Thomas Andersen (SAIF), Defense Attorney

WCB 88-02426
December 13, 1989
Order on Review

Reviewed by Board Members Howell and Perry.

The SAIF Corporation requests review of Referee Gruber's order that assessed a penalty and associated attorney fee for its allegedly unreasonable failure to accept or deny medical bills in timely fashion. We reverse.

ISSUE

Penalty and attorney fee for SAIF's allegedly unreasonable failure to accept or deny medical bills in timely fashion.

FINDINGS OF FACT

Claimant injured her neck and left shoulder in August 1986. SAIF accepted her claim for the injury. Later, claimant was diagnosed as having carpal tunnel syndrome. SAIF denied this condition and claimant and SAIF entered into a disputed claim settlement of the condition on June 10, 1987.

Claimant's compensable neck and left shoulder condition remained open after the disputed claim settlement. On August 10, 1987, the claims examiner monitoring claimant's claim sent claimant a letter which stated that she would take steps to close the claim unless she received further medical information which indicated that claimant's condition was not medically stationary.

On October 23, 1987, SAIF received medical bills from a medical clinic and a neurology clinic in Minnesota which totaled $232. The bills referenced claimant's name and the the date of her industrial injury and indicated that the charges related to an EMG examination. SAIF's claims examiner returned the bills to the respective clinics on November 13, 1987 with a letter requesting additional information about the services which generated the bills. The clinics responded by sending copies of the previous bills. On January 20, 1988, the examiner again returned the bills and repeated its request for additional information. She also sent a letter to claimant's attorney requesting assistance in resolving the problem. Claimant's attorney responded by filing a request for hearing which asked for penalties and attorney fees for SAIF's failure to pay the medical bills.

As of the time of the hearing, SAIF had not yet received the additional information it had requested from the Minnesota clinics. The parties reserved the issue of the compensability of the disputed medical bills for later litigation.

FINDINGS OF ULTIMATE FACT

SAIF's failure to accept or deny the disputed medical bills within 60 days of receiving them was reasonable.

CONCLUSIONS OF LAW

ORS 656.262(6) requires a carrier to give a claimant written notice of acceptance or denial of a claim within 60 days of

the carrier's notice or knowledge of a claim. This requirement applies to claims for rendered medical services. Billy J. Eubanks, 35 Van Natta 131, 135 (1983). A carrier which unreasonably delays acceptance or denial of a claim may be liable for penalties and attorney fees. ORS 656.262(10), 656.382(1).

The Referee concluded that SAIF acted unreasonably in failing to deny the medical bills it received from Minnesota within 60 days of first receiving them. We disagree. OAR 436-10-100(3) provides: "Insurer shall pay bills for medical services within 60 days of receipt of the bill, if the billing is submitted in proper form and clearly shows that the treatment is related to the accepted compensable injury or disease. . . ." (emphasis added).

SAIF did not accept or deny the bills within 60 days because it did not have sufficient information about the nature of the charges to determine whether they related to claimant's compensable neck and left shoulder condition, her noncompensable carpal tunnel syndrome or some other condition. It made reasonable efforts to obtain this information and was continuing to do so at the time claimant filed her request for hearing. Under these circumstances, we conclude that SAIF's failure to meet the 60-day deadline was reasonable. See Ronald A. Shamberger, 40 Van Natta 993 (1988). Consequently, there is no basis for a penalty or attorney fee.

ORDER

The Referee's order dated March 18, 1988 is reversed.

RALPH S. NUTTING, Claimant	WCB 87-17860
Welch, et al., Claimant's Attorneys	December 13, 1989
Cummins, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of that portion of Referee Schultz's order that granted claimant an award of permanent total disability, beyond prior Determination Order awards of 25 percent (90 degrees) unscheduled permanent disability for the low back and 20 percent (30 degrees) scheduled permanent disability for the left leg. On review, the issues are permanent total disability and the extent of both unscheduled and scheduled permanent disability.

The Board reverses the order of the Referee.

FINDINGS OF FACT

Claimant, 63, compensably injured his left knee and low back in July, 1986, while employed as a machine operator for the employer, a plywood mill. He sought treatment from Dr. Norquist, M.D. Due to persistent pain, he underwent arthroscopic knee surgery in November, 1986, followed by a bilateral lumbar laminectomy in March, 1987. A Determination Order closed his claim in May, 1987, with an award of 20 percent scheduled permanent disability and a period of temporary disability.

Vocational rehabilitation services were commenced in August, 1987. Claimant fully cooperated with unsuccessful efforts to return him to work.

A second Determination Order issued in October, 1987, which awarded 25 percent unscheduled permanent disability for the low back and an additional period of temporary disability.

Claimant has mild permanent physical impairment due to the low back and minimal impairment due to the left knee. His ability to walk is quite limited. He must be allowed to constantly change positions, as he is unable to tolerate prolonged periods of walking, standing, or sitting. In addition, he is unable to perform any bending, lifting, or twisting. He completed high school and took some college business administration classes in 1944. He has prior work experience as an insurance underwriter, a security alarm salesman, a representative for a business school, and a machine operator.

Claimant has the physical capacity and transferable skills to regularly perform work at a gainful and suitable occupation. He is presently capable of working as a long distance telephone salesman, parking lot attendant, photo processor, and proof reader.

CONCLUSIONS OF LAW

Permanent Total Disability

A worker may prove permanent total disability based solely on his physical disability or from a combination of his physical disability and social/vocational factors. Clark v. Boise Cascade Co., 72 Or App 397 (1985); Emerson v. ITT Continental Baking Co., 45 Or App 1089 (1980). Unless it would be futile, a worker is required to make reasonable efforts to obtain regular gainful employment. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Here, claimant is not totally physically disabled. In Norquist's most recent report, dated February 25, 1988, he stated:

> "[Claimant] could well perform the physical activities that I do as a physician or that you, [insurer's attorney], perform as an attorney. That is, to sit or stand, or walk very short distances with the chance to change attitude or position frequently and without the need to bend, twist or stoop or to lift heavy objects."

Likewise, after performing claimant's low back surgery, Dr. Hummel, a neurosurgeon, opined in July, 1987, that claimant should seek some "lighter activity." Two months later, Rosenbaum reported that claimant had only "mild" permanent impairment in his low back. He added that claimant was "employable in an occupation which would not involve heavy bending, lifting, twisting and would not involve prolonged walking."

Under such circumstances, we conclude that claimant's physical disability alone does not entitle him to an award of permanent total disability.

We turn to an examination of both his physical disability and the relevant social/vocational factors (i.e., the "odd-lot" doctrine). Claimant is significantly disabled given his low back and left knee impairments. He is 63 years of age and,

several years ago, completed some city college classes in business administration. There is no evidence that his present mental capacities are below average. His transferable skills to lighter occupations derive from a diverse employment history. He has worked as a salesman, a representative for a business school, an insurance underwriter, and a machine operator.

We must determine whether claimant has the necessary skills and physical capacity to regularly perform gainful and suitable occupations. Buckland persuasively testified that claimant could presently perform a variety of jobs, including telephone sales, wholesale electric sales, insurance sales, parking lot attendant, photo processor, proof reader, and marketing positions. Her expert opinion is unrebutted. It is also consistent with the view of the medical experts that claimant is capable of performing sedentary or light occupations. Moreover, we conclude that the jobs suggested by Buckland are gainful and suitable occupations.

Accordingly, on this record, we conclude that claimant has not proven that he is presently incapacitated from regularly performing work at gainful and suitable occupations.

Unscheduled and Scheduled Permanent Disability

Unscheduled permanent disability is awarded for the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining loss of earning capacity, we consider the worker's physical impairment and all of the the relevant social/vocational factors set forth in former OAR 436-30-380 et seq. We apply such factors as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Here, claimant has mild permanent physical impairment with respect to his low back condition. His ability to walk, stand, sit, bend, twist, and lift have been limited by the July, 1986, injury. In addition, he experiences constant low back pain. Considering his mild impairment, his advanced age, his relatively limited education, and his inability to return to machine operator occupations, we conclude that he has permanently lost 75 percent of his earning capacity.

Scheduled permanent disability is awarded for a worker's permanent loss of use or function of the injured member. ORS 656.214(1) & (2) et seq. Claimant's reduced ability to walk relates, in part, to his left knee disability. However, his current treatment and complaints have largely focused on his low back disability. After considering the medical and testimonial evidence, we conclude that claimant's prior award of 20 percent scheduled permanent disability, appropriately compensates him for his permanent loss of use or function of the left knee.

ORDER

The Referee's order, dated April 15, 1988, is reversed. In lieu of the Referee's award of permanent total disability, and in addition to the Determination Order award of 25 percent (80 degrees) uncheduled permanent disability, claimant is awarded 50 percent (160 degrees) for his low back condition, for a total unscheduled award to date of 75 percent (240 degrees). Claimant's

attorney is awarded a fee equal to 25 percent of the additional compensation awarded by this order, to be paid out of that compensation, and not to exceed $3,000. A client-paid fee, not to exceed $1,792.50, is approved.

ROBERT STAFFORD, Claimant
Daryll E. Klein, Defense Attorney

WCB 87-16630
December 13, 1989
Order on Review (Remanding)

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Bennett's order that dismissed his request for hearing. On review, the issue is dismissal of claimant's hearing request.

FINDINGS OF FACT

A hearing was scheduled in this case for January 20, 1988, at claimant's request. A tentative settlement was reached at the time of that hearing. Subsequently, however, claimant refused to sign a written stipulation and discharged his attorney. The hearing was rescheduled for April 4, 1988. Claimant failed to appear. Consequently, the Referee issued an Order of Dismissal on April 5, 1988, dismissing claimant's request for hearing.

On April 27, 1988, claimant filed a document with the Workers' Compensation Board, entitled:

"REQUEST TO APPEAL
REQUEST FOR NEW HEARING DATE ON CLAIM
AND ORDER OF DISMISSAL BE WITHDRAWN."

The record does not establish whether that document was ever seen by the Referee. Several months later, claimant wrote the Referee inquiring as to the status of his request for a new hearing.

CONCLUSIONS OF LAW

In Mark R. Luthy, 41 Van Natta 2132 (November 21, 1989), we held that former OAR 438-06-071 required a Referee to rule on a request for postponement even after an order of dismissal had issued, so long as the Referee retained jurisdiction. Here, it appears that the April 27, 1988, document was treated solely as a request for Board review and was not forwarded to the Referee for a ruling on the request for postponement. Pursuant to Mark R. Luthy, supra, we remand to the Referee for such a ruling. Should the Referee determine that "extraordinary circumstances" existed under former OAR 438-06-081, the April 4, 1988, hearing shall be postponed and a new hearing scheduled. Should the Referee determine that claimant has not proven "extraordinary circumstances," the Order of Dismissal shall be reinstated.

ORDER

The Referee's order, dated April 5, 1988, is vacated and the case is remanded to Referee Bennett for further proceedings consistent with this order. If the Referee determines that a postponement of the April 4, 1988, hearing should be granted, the Referee shall proceed with a hearing concerning the merits of the claim.

VELDON BURGESS, Claimant
Michael B. Dye, Claimant's Attorney
Ann Kelley, Assistant Attorney General

WCB 87-19083
December 14, 1989
Interim Order Remanding

Department of Justice, Inmate Injury Fund, requests review of that portion of Referee Hettle's order that: (1) found that claimant's shoulder and head injury claim should not be barred for untimely filing; (2) set aside the Department's denial of the same claim; and (3) awarded claimant's counsel a $1,400 attorney fee, payable by the Inmate Injury Fund. We remand for further evidence.

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. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

Here, claimant's injury claim was denied by the Department on the grounds that it was not timely filed within the 90 days allotted by ORS 655.520(3). The statute requires a written claim to be filed with the Department within 90 days after the injury. Id.

As noted in the Referee's order, the official in charge of inmates' claims for benefits received a written memorandum from claimant's supervisor regarding claimant's injury. However, the memorandum was not introduced at the hearing. We conclude the memorandum is relevant on the timely filing issue. Under such circumstances, we find that the record has been incompletely developed.

Furthermore, prior to the hearing, claimant's attorney requested that the Department re-check its records in order to identify how the claim was processed. The Department replied that it had not received a claim for injuries, and it did not provide claimant's attorney with the memorandum within its control. Therefore, although claimant acted with due diligence, the evidence was not available at the time of hearing.

Accordingly, this case is remanded to the Presiding Referee for the introduction of evidence concerning the memorandum that pertained to claimant's injuries and was received by safety sanitation officer DeForest from claimant's supervisor.

The Board retains jurisdiction over this case. Upon receipt of additional evidence regarding the above referenced memorandum, the Presiding Referee shall issue an Interim Order on Remand discussing the effect, if any, this evidence has upon the prior Referee's order. Thereafter, the Board shall take this matter under advisement.

ORDER

This case is remanded to the Presiding Referee for further action consistent with this order.

ALAN C. CHURCH, Claimant
Peter O. Hansen, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 85-04704
December 14, 1989
Order on Reconsideration

The SAIF Corporation requests reconsideration of those portions of the Board's November 15, 1989 Order on Review that: (1) directed that SAIF pay to claimant permanent disability compensation which SAIF had unilaterally offset, while allowing SAIF an offset of the compensation ordered paid against future awards of permanent disability; and (2) awarded claimant a penalty-related attorney fee as well as an attorney fee payable out of the increased compensation granted by our order.

With regard to the offset issue, we adhere to our prior decision.

With regard to the attorney fee issue, SAIF contends that our decision results in a "double fee" to claimant's attorney for "the same attorney services." SAIF argues that a "double fee" is prohibited by statute, administrative rule, the attorney fee agreement between claimant and his counsel, and policy considerations. We do not agree with SAIF's argument regarding a "double fee." However, we conclude that the award of an approved fee payable out of claimant's compensation was otherwise incorrect.

In our prior order, we concluded that SAIF was not permitted to take an offset in the absence of prior authorization to do so. We, therefore, directed that SAIF repay the amounts previously offset. In addition, we awarded claimant's attorney an approved fee payable out of the "increased" compensation granted to claimant by our order. See ORS 656.386(2); OAR 438-15-005(1).

However, pursuant to our order, we did not award claimant any "increased" compensation; rather, we directed that SAIF pay compensation which had been previously awarded by Determination Order. Therefore, on further consideration, we conclude that an award to claimant's attorney of an out-of-compensation fee is not supported by statute. See Forney v. Western States Plywood, 297 Or 628 (1984), on remand 37 Van Natta 91 (1985); Steven R. Pace, 38 Van Natta 139 (1986).

Accordingly, the motion for reconsideration is granted. That portion of our prior order which awarded claimant's attorney an out-of-compensation fee is withdrawn. On reconsideration, as amended herein, we adhere to and republish our November 15, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

PATRICIA L. DUERR, Claimant
Coons & Cole, Claimant's Attorneys
Luvaas, et al., Defense Attorneys

WCB 89-09814
December 14, 1989
Second Order of Dismissal

Claimant requests reconsideration of our November 29, 1989 order which dismissed claimant's request for Board review. Specifically, claimant objects to our finding that "[t]here is no record that claimant's reconsideration request [of the Referee's order] was received by the Referee or Board until November 17, 1989." Asserting that his request was received by the Referee "well within the 30-day appeal" period, claimant seeks reconsideration.

Since the issuance of our order, the Referee has forwarded to the Board claimant's October 11, 1989 request for reconsideration of the Referee's order. The request indicates that it was received by the Hearings Division on October 12, 1989.

We alter our prior order to find that claimant's request was received by a permanently staffed office of the Board on October 12, 1989. However, this alteration to our findings does not change our ultimate conclusion that the request does not constitute a request for Board review of the Referee's September 22, 1989 order. As we previously reasoned, claimant's October 11, 1989 request unambiguously sought reconsideration, rather than Board review, of the Referee's September 22, 1989 order.

Accordingly, our November 29, 1989 order is withdrawn. 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.

DEWEY H. GILKEY, Claimant	WCB 84-13492, 85-10096, 85-10535
Malagon & Moore, Claimant's Attorneys	& 86-03407
Kate Donnelly (SAIF), Defense Attorney	December 14, 1989
John Littlefield, Defense Attorney	Order of Abatement

On our own motion, we abate and withdraw our Order on Review in the above-captioned case, issued November 20, 1989. We take this action to reconsider the compensability ruling in that order. After we have completed our further consideration of this matter, an order on reconsideration will issue.

IT IS SO ORDERED.

DANIEL L. GROUSBECK, Claimant	WCB 87-05636
Rasmussen & Henry, Claimant's Attorneys	December 14, 1989
Nancy C. Marque (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Livesley's order that: (1) upheld the SAIF Corporation's "de facto" denial of chiropractic treatments in excess of four per month; and (2) rejected his request for a penalty and associated attorney fee for SAIF's failure to pay or deny the disputed treatments in a timely manner. The issues are medical services, penalties and attorney fees. We affirm.

The Board adopts the Referee's findings of fact and conclusions of law with the following supplementation.

FINDINGS OF FACT

Claimant's treating chiropractor, Dr. Thomas, billed SAIF in May 1987 for a number of treatments. On June 24, 1987, SAIF sent Dr. Thomas a form requesting justification for treatments in excess of four per month. Dr. Thomas completed the form and returned it to SAIF. SAIF received the form on August 10, 1987. SAIF paid for only a portion of Dr. Thomas'

treatments and never issued a formal denial of the other treatments. On August 13, 1987, claimant filed a request for hearing in connection with SAIF's failure to pay for the disputed treatments. The hearing was held on February 10, 1988.

FINDINGS OF ULTIMATE FACT

SAIF failed to issue a formal denial within 60 days of receiving bills for medical services for which it did not pay. This failure was unreasonable.

CONCLUSIONS OF LAW

A carrier is liable for a penalty of up to 25 percent of compensation "then due" and an associated attorney fee if it unreasonably delays acceptance or denial of a claim. ORS 656.262(10), 656.382(1). In the absence of a reasonable explanation for a longer delay, bills for rendered medical services must be paid or denied within 60 days of their receipt by the carrier. See ORS 656.262(6); Billy J. Eubanks, 35 Van Natta 131, 135 (1983).

In the present case, SAIF failed to accept or deny the disputed medical services within 60 days and offers no reasonable explanation for a longer delay. SAIF's failure to pay or deny the medical services within 60 days, therefore, was unreasonable. No penalty may be assessed, however, because the medical services are not compensable and thus were never "due" within the meaning of ORS 656.262(10). Furthermore, an attorney fee may not be assessed for unreasonable resistance to the payment of compensation because no compensation was payable. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989).

On review, claimant argues that the Referee erred in reaching the issue of whether those chiropractic services claims, which were not paid by SAIF, were compensable. Claimant argues that "de facto" denials are impermissible under Workers' Compensation Law. For the following reasons, we need not address that issue.

Claimant requested a hearing in this matter. In an August 13, 1987 supplemental request, claimant raised the issue of entitlement to medical services. At hearing, one issue agreed upon by the parties was the ". . . failure to pay Dr. Thomas's (sic) chiropractic services . . ." (Tr. p. 3 & 4). We conclude that the parties treated the claims for Dr. Thomas' services as denied and litigated that issue. Claimant's request for review supports that conclusion. Claimant alleges that the Referee erred in failing to find SAIF responsible for claimant's medical bills.

Furthermore, it was necessary for the Referee to determine whether the unpaid chiropractic bills were compensable in order to determine if there were "amounts then due" under ORS 656.262(10) against which the penalty requested by claimant could be assessed. Likewise, ORS 656.382(1) provides for an attorney fee for unreasonable resistance to the payment of "compensation."

In conclusion, this case is controlled by the holdings in John D. Ellis, 39 Van Natta 319 (1987); Ellis v. McCall Insulation, 93 Or App 188 (1988); and Ellis v. McCall Insulation, 308 Or 74 (1989).

ORDER

The Referee's order, dated April 4, 1988, is affirmed.

CHARLES H. HANNAH, Claimant
Michael J. Dooney, Claimant's Attorney
Patrick Lavis, Attorney
David B. Smith (SAIF), Defense Attorney

WCB 84-03681
December 14, 1989
Order on Review

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Fink's order which upheld the SAIF Corporation's denial of his occupational disease claim for his psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the findings of fact included in the "Findings" section of the Referee's order. We make the following additional findings.

Claimant worked for SAIF's insured as an assistant administrator in the county corrections division. His job duties included writing reports, supervising corrections officers and monitoring the jail security system. Claimant worked an average of six days a week and was often asked to return to the jail at night to assist with computers or surveillance equipment.

At various times, the sheriff or the personnel director asked claimant to report on the work activities of his superiors. There were often confrontations between factions of officers at the jail, and claimant felt that it was his obligation to resolve such conflicts.

Claimant and his wife had experienced marital difficulties for several years and were separated for a few months in 1983. They had also encountered visitation problems in regard to claimant's children from a previous marriage.

In December of 1983, claimant spent two weeks at an officer's convention. On the day of his return from the convention, he was arrested for shoplifting. Several days later, due to the shoplifting charges brought against him, claimant resigned from his position as assistant administrator.

FINDINGS OF ULTIMATE FACT

Claimant's work with SAIF's insured was objectively capable of causing stress. Claimant's job stressors were not the major contributing cause of his depression condition.

CONCLUSIONS OF LAW

We adopt the conclusions and opinion of the Referee with the following supplementation.

The Referee found that claimant's work environment was not the major contributing cause of his depression condition. We agree.

Stress-related claims for benefits arising out of mental

and physical disorders are compensable if they flow from objectively existing conditions of the worker's employment, and if those work conditions, when compared to non-employment conditions, are the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145 (1983). When claimant's condition involves a complex issue of medical causation, a resolution of the controversy can best be achieved through an appraisal of the medical opinions. Linda C. Viles, 39 Van Natta 14 (1987) aff'd mem Viles v. SAIF, 89 Or App 569 (1988).

Dr. Beahrs, claimant's treating psychiatrist, concluded that on-the-job stressors were the major cause of claimant's depression. Although Dr. Beahrs had been informed of the shoplifting incidents, he was not aware of claimant's marital or family problems when he made his diagnosis.

Dr. Wittrop, an examining psychiatrist, was given a history which included claimant's job stressors, shoplifting incidents and marital difficulties. Dr. Wittrop could not assign a "major contributing cause" designation to on-the-job stressors. He subsequently estimated that work stressors contributed to 25 percent of claimant's current problem.

A third psychiatrist, Dr. Colbach, reported that due to claimant's marital problems, he could not conclude that job stressors were the major contributing cause of claimant's psychological problem. Dr. Colbach noted the statements made by both claimant and his wife that claimant's mental state had deteriorated rapidly after his resignation.

Although claimant's treating doctor had the opportunity to observe him upon more than one occasion, we cannot rely upon his medical opinion due to the fact that claimant's marital and family problems were not considered in its formulation. Where there is a dispute between medical experts, more weight is given to those opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Under the circumstances, we find the medical opinions of Drs. Wittrop and Colbach to be more persuasive in regard to the issue of causation of claimant's stress condition. We conclude that, although claimant's work was objectively capable of causing stress, it was not the major contributing cause of claimant's disorder. Accordingly, claimant's occupational disease claim is not compensable.

ORDER

The Referee's order dated July 17, 1987 is affirmed.

JERRY P. MILLER, Claimant	WCB 86-07920
Philip H. Garrow, Claimant's Attorney	December 14, 1989
Meyers & Radler, Defense Attorneys	Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Thye's order which: (1) upheld the self-insured employer's denial of claimant's right carpal tunnel syndrome; (2) found that certain medical services were not for diagnostic purposes; (3) declined to assess penalties and attorney fees for an alleged late denial; (4) declined to

award scheduled permanent disability for the loss of use or function of the right arm; and (5) declined to award unscheduled permanent disability for the right shoulder. Claimant has also moved for remand, for introduction of additional evidence to establish when the insurer had notice of his carpal tunnel claim. On review, the issues are remand, compensability, medical services, penalties and attorney fees, and extent of permanent disability.

We affirm in part and reverse in part.

FINDINGS OF ULTIMATE FACT

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

The June 10, 1986 medical report authored by Dr. Rinehart, containing an impression of carpal tunnel syndrome, was received by the employer in July 1986.

CONCLUSIONS OF LAW AND OPINION

On the questions of the compensability of claimant's carpal tunnel syndrome, the existence of any scheduled permanent disability, and the existence of any unscheduled permanent disability, we agree with the Referee. Claimant has failed to meet his burden of proof. Consequently, we adopt those portions of the Referee's conclusion.

On the question of whether claimant's examinations and treatments by Dr. Rinehart and Dr. Buchholz were compensable for diagnostic purposes, we reverse in part. The Referee reasoned that for such treatments to be compensable, claimant must be seeking a diagnosis of his symptoms not merely curative treatment. We disagree. The test in this case is whether claimant has shown by a preponderance of the evidence that a diagnostic procedure is reasonable and necessary medical service to determine whether his condition is causally related to the compensable injury. Myrtle L. Thomas, 35 Van Natta 1093, 1095 (1983).

Claimant went to see Dr. Rinehart with symptoms of numbness and loss of strength in his right arm and shoulder. These symptoms were similar to those he was experiencing at the time of his claim closure in 1985. Dr. Rinehart suspected claimant might be suffering from carpal tunnel syndrome and sent claimant to Dr. Buchholz for an evaluation. Dr. Buchholz administered tests which led him to suspect carpal tunnel syndrome. However, Buchholz remained unsure of his suspicion until he had done further research to rule out the possibility that claimant's problems were the result of his earlier compensable injury. Claimant was returned to the care of Dr. Rinehart, who treated him for carpal tunnel syndrome. Claimant has met his burden of proof in establishing that his initial visits to Dr. Rinehart and Dr. Buchholz and the tests ordered by Dr. Buchholz were reasonably necessary medical services to determine whether his condition was causally related to his compensable injury. Claimant's subsequent visits to Dr. Rinehart for treatments of carpal tunnel syndrome, were not compensable.

We turn to the penalty and attorney fee issue. The Referee held that claimant had failed to provide evidence as to

when the employer had received notice of a claim for carpal tunnel syndrome and denied the request for a penalty and attorney fee for a late denial. We disagree.

We find that the employer received Dr. Rinehart's June 10, 1986 report in July 1986. In reaching this conclusion, we note that the report carries the employer's date stamp of "+7._.86." The employer failed to deny claimant's carpal tunnel syndrome until November 7, 1986. The employer failed to accept or deny the claim within 60 days and claimant is entitled to a penalty and a reasonable attorney fee. ORS 656.262(10). A penalty in the amount of 25 percent of the amount owing for the initial visits to Dr. Rinehart and Dr. Buchholz and the tests ordered by Dr. Buchholz, as well as a reasonable attorney fee, are assessable. As we have reached this conclusion we need not address the remand motion.

Claimant's brief was rejected as untimely. There is no evidence that additional legal services were provided on Board review. Therefore, no attorney fee will be awarded to claimant's attorney for prevailing on review. Shirley Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order, dated April 14, 1988, is affirmed in part and reversed in part. That portion of the employer's denial which denied diagnostic medical services is set aside. The self-insured employer is directed to pay claimant's medical services claims for his June 10, 1986 visit to Dr. Rinehart and his June 16, 1986 visit to Dr. Buchholz, as well as the medical tests connected with Dr. Buchholz's examination. As a penalty for its unreasonable claims processing, the employer shall pay claimant a penalty of 25 percent of the aforementioned amounts due. For services rendered at hearing, concerning the denial of diagnostic medical services, claimant's attorney is awarded a reasonable fee of $1,000, to be paid by the employer. For services concerning the penalty issue, claimant's attorney is awarded a reasonable fee of $300, to be paid by the employer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $638, is approved.

PAMELLA K. PRUETT, Claimant	WCB 87-18814
Charles D. Maier, Claimant's Attorney	December 14, 1989
Acker, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Higashi's order that: (1) upheld the insurer's denial of claimant's aggravation claim for her low back condition; (2) declined to assess a penalty and fee for the insurer's alleged late payment of interim compensation; and (3) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review, the issues are aggravation, penalties and attorney fees. We affirm in part and reverse in part.

FINDING OF FACT

Claimant compensably injured her back, neck, left shoulder and arm on October 10, 1985. Her condition was diagnosed as cervical, left deltoid, and lumbosacral strain. On August 25,

1986 a Determination Order closed the claim with no permanent disability award. A December 23, 1986, Referee's order awarded 35 percent unscheduled permanent disability for the low back. On September 29, 1987, the Board reduced claimant's award to 5 percent. Pamella K. Pruett, 39 Van Natta 821 (1987).

Claimant did not return to work following the October 10, 1985 compensable injury. On June 4, 1987, Dr. Arden requested the insurer approve the purchase of a TNS unit. It was maintained that this unit would relieve pain that claimant was suffering from the compensable injury. (Ex. 2). On October 15, 1987, Dr. Arden found that claimant was unable to work due to the pain. (Ex. 5).

The insurer received Dr. Arden's report on October 21, 1987. It did not begin paying compensation until November 29, 1987. On December 15, 1987, the Independent Chiropractic Consultants performed an independent medical examination and concluded that claimant had maintained her medically stationary status.

On December 21, 1987, the insurer issued a denial alleging that claimant had not suffered an aggravation since the last award of compensation.

ULTIMATE FINDINGS OF FACT

Claimant's condition resulting from her October 10, 1985 injury has not worsened since her last award or arrangement of compensation. At the time of its denial, the insurer had a legitimate doubt concerning the compensability of claimant's aggravation claim.

The insurer unreasonably failed to begin paying claimant's interim compensation within 14 days from the date of notice of a medically verified inability to work.

CONCLUSIONS OF LAW

The Referee stated that to establish a compensable aggravation claim, claimant must show a worsening of the injury related condition, a causal relationship between the compensable injury or disease and the worsened condition, and at least a temporary increase in disability. The Referee found that a compensable aggravation claim could not be sustained. We agree with the Referee's conclusions, but based on the following reasons.

In order to establish a compensable aggravation, claimant must show "worsened conditions resulting from the original injury." ORS 656.273; see Perry v. SAIF, 307 Or 654 (1989). In addition, claimant must establish that as a result of such worsening he is more disabled, i.e., less able to work, either temporarily or permanently than he was at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396, 399 (1986). "Worsened conditions" may be either a change of the underlying condition or an increase in symptoms. worsening. Id. Gwynn v. SAIF, 305 Or 345, on remand 91 Or App 84 (1988).

In our view, claimant has not shown that her condition has objectively or symptomatically worsened. On June 4, 1987, Dr. Arden requested that the insurer pay for a TNS unit. At that

time, there was no mention of claimant's condition worsening. Subsequently, on October 15, 1987, Dr. Arden alleged that claimant had suffered an exacerbation of the injury, and related this worsening back to March 17, 1987. Yet, Dr. Arden offers no reasonable explanation as to why he did not mention this important event in his June 4, 1987, request for the TNS unit. Consequently, we find Dr. Arden's opinion unpersuasive. Furthermore, the Independent Chiropractic Consultants' report is detailed and well-reasoned. The Consultants concluded that claimant had retained her medically stationary status and that no further treatment was necessary. (Ex. 8-5). We find their opinion persuasive.

We may properly review the substance of claimant's prior testimony from the 1986 hearing, inasmuch as the transcript of that proceeding is part of this record. In comparing that prior testimony, which was rendered before the last arrangement of compensation, to her current testimony, we are not persuaded that she has experienced a change in symptoms. Her complaints of pain are essentially unchanged. Accordingly, we are not persuaded that claimant's condition resulting from the original injury has worsened.

We turn to the issue of penalties and attorney fees for the insurer's untimely payment of interim compensation.

The insurer received medical verification of claimant's inability to work as a result of her worsened condition on October 21, 1987. However, the insurer did not commence paying interim compensation until November 21, 1987.

The Referee found that payment of temporary disability benefits were "late". Although the Referee awarded a $250 penalty associated attorney fee, he declined to assess a penalty. We find that the Referee's attorney fee award is reasonable, but we conclude that a penalty is justified.

In the absence of a justifiable explanation, we consider the insurer's failure to pay the aforementioned benefits within 14 days of the insurer's notice of medical verification to represent an unreasonable delay in the payment of claimant's compensation. Accordingly, a penalty is also warranted. See ORS 656.273(6); 656.262(10). The penalty shall be based on the amount "then due" at the time of the insurer's untimely payment.

ORDER

The Referee's order, dated June 8, 1988, is reversed in part and affirmed in part. As a penalty for its untimely payment of interim compensation, the insurer shall pay claimant 25 percent of the amounts then due at the time of its November 25, 1987 payment. All remaining portions of the Referee's order are affirmed.

PAUL E. VOELLER, Claimant	WCB 86-09287
Peter O. Hansen, Claimant's Attorney	December 14, 1989
Schwabe, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Neal's order which: (1) set aside its denial of claimant's occupational disease claim for depression or major affective

disorder; and (2) awarded claimant's attorney a fee of $4,500. On appeal, the issues are compensability and attorney fees.

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

In its request for review, the employer raises issues not addressed by the Referee's order.

The employer argues that the standard for compensability of a mental disorder established in the present version of ORS 656.802, effective January 1, 1988, should apply. We disagree. In order for the new law to apply, there must have been an exposure to the injurious employment after January 1, 1988. Ellen L. Crawford, 41 Van Natta 1257 (1989). Claimant's last exposure to his employment occurred on April 21, 1986.

Concerning the Referee's attorney fee award, the employer argues that procedural defects in the filing of claimant's attorney's statement of services made such an award an error. The hearing was closed on March 31, 1988. Claimant's attorney mailed his statement of services to the Referee on April 1, 1988. Claimant's attorney neglected to send a copy of the statement of services to the employer or its attorney and no certificate of service was included with the statement of services mailed to the Board. The employer's attorney was provided an unsigned copy of claimant's attorney's statement of services on April 19, 1988.

"Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing." OAR 438-05-046(1)(a). Claimant's attorney's statement of services was properly filed. Although the employer and its attorney were not served at the time of filing of the statement of services, the record reveals that the employer raised an objection to the amount of the attorney fee in a letter to the Referee on April 21, 1988. In this letter, the employer's attorney acknowledged the receipt of a copy of claimant's attorney's statement of services. The Referee considered these arguments and, in a letter dated May 9, 1989, declined to change the fee awarded.

Under such circumstances, we conclude that the employer's late receipt of its copy of claimant's attorney's statement of services did not prevent it from presenting its position concerning claimant's attorney fee award. In any event, on de novo review, we find an attorney fee of $4,500 reasonable for claimant's counsel's services at hearing. See OAR 438-15-010(6); Billy J. McAdams, 41 Van Natta 2019 (November 8, 1989).

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review concerning the compensability issue. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated April 15, 1988, is affirmed. The Board approves a client-paid fee not to exceed $1,890.50, payable from the employer to its counsel.

FRANK R. YAMBRA, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 88-02275
December 14, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Menashe's order that: (1) upheld the self-insured employer's partial denial of his left knee condition and need for surgery and further medical services; and (2) upheld its "de facto" denial of his occupational disease claim for the same condition. On review, the issue is compensability.

We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant has a history of preexisting left leg and knee problems, which began several years ago. In the early 1940's, he sustained a compound fracture of his left leg in a nonindustrial automobile accident. This fracture incorrectly healed producing a vargus deformity. As a result, the angulation of the weight bearing forces of his left knee was altered. In the mid-1960's, he injured his left knee at work. No claim was filed for that injury.

Claimant began working for the employer as a meat cutter in February 1947. He sustained a nondisabling compensable injury to his left knee on December 23, 1982. At that time, he had significant arthritic changes in his left knee. On January 3, 1986, he sustained a compensable disabling injury to his right hip. A few months later, he retired from his work as a meat cutter. The claim was closed by Determination Orders of July 29, 1986, and August 14, 1986, which awarded him 25 percent unscheduled permanent disability for the low back and 35 percent scheduled permanent disability for the right leg.

In September, 1987, the employer formally denied the compensability of claimant's arthritic left knee condition as not materially related to the January, 1986, injury. Claimant did not timely request a hearing to contest the denial. In December, 1987, the employer issued a second formal denial. This later denial denied that claimant's left knee condition was a result of the December, 1982, injury. Claimant filed a timely request for hearing from this denial.

Claimant filed an occupational disease claim for his left knee condition, by way of a report from Dr. Nelson, his treating physician, dated January 4, 1988. The employer received Nelson's report on January 6, 1988, but did not formally accept or deny an occupational disease within 60 days thereafter.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proven neither a material causal connection between the nondisabling 1982 left knee injury and his current arthritic condition, nor that his 40 years of work exposure was the major contributing cause of his condition. We agree and adopt the "Conclusions And Decision" section of the Referee's order.

We note, however, that the employer's December, 1987,

denial states: "[A]ny ongoing medical treatment to the left knee must be denied." Claimant timely requested a hearing and sought to set aside that denial. Regardless of the precise legal argument asserted by claimant at either hearing or on Board review, the issue of the compensability of his arthritic condition and the medical services denied by the December, 1987, denial, were properly before the Referee.

It is well settled that an employer cannot prospectively deny future medical services when a worker has an accepted underlying claim. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, claimant has a compensable 1982 injury for a left knee condition. By virtue of our above conclusion that the Referee correctly found no material contribution between claimant's current arthritic condition and the 1982 injury, claimant's current treatment for the left knee is not compensable. Nevertheless, claimant has a right to continued medical services under the accepted 1982 claim. ORS 656.245(1). To be sure, claimant must prove entitlement to all current services each time the employer issues a medical services denial. ORS 656.245(1) states that compensable medical services must "result[] from the [compensable] injury * * *." It is impermissible, however, for an employer to prospectively deny "any ongoing medical treatment."

Accordingly, we reverse the Referee to the extent that he upheld the employer's December, 1987, denial in its entirety. That portion of the denial that prospectively denied future treatment is set aside.

Claimant's attorney is entitled to an assessed attorney fee for services at hearing and on Board review for partially setting aside the employer's denial. Inasmuch, as no statement of services has been received from claimant's attorney to date, we are presently unable to award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order, dated July 6, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that upheld the employer's December, 1987, denial, insofar as it prospectively denied future medical treatment of claimant's left knee, is reversed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, payable by the self-insured employer to its counsel, not to exceed $1,096.

DIANA BROWN, Claimant	WCB 88-01933
Rex Q. Smith, Claimant's Attorney	December 15, 1989
Carroll Smith (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Tenenbaum's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for her left leg (knee) condition; and (2) declined to assess penalties and attorney fees for the alleged unreasonable denial. On review, the issues are aggravation and penalties and attorney fees. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant compensably injured her left knee in 1983. A

December 1983 Determination Order awarded 5 percent scheduled permanent disability for claimant's left leg (knee). Claimant continued to complain of flare-ups of pain after the closure. Her claim was reopened in early 1984 for further medical treatment and temporary disability benefits. An arthroscopy performed in March 1984 was entirely normal. Claimant was medically stationary on August 14, 1984. At that time, she complained of moderate to severe knee pain.

A Determination Order issued September 1984, awarding additional temporary disability compensation but no increase in permanent disability. A June 1985 stipulation increased claimant's scheduled permanent disability award to 12.5 percent.

Claimant returned to work at an answering service in June 1985. In August 1985, she was terminated for reasons unrelated to her compensable injury. Claimant did not return to work until early December 1987. Several hours after beginning work as a store clerk, claimant left the job; and a few days later, she sought treatment for knee pain from Dr. Dougan, M.D.. Range of motion findings at that time were similar to findings in 1984. Dr. Dougan released claimant for modified work. She returned for further treatment in mid-December 1987, complaining of severe knee pain while walking. Objective findings included effusion, but no swelling or instability. An arthrogram performed in late December 1987 demonstrated no significant abnormalities of the medial meniscus, but a possible lateral meniscus lesion. Arthroscopic surgery to confirm the latter finding was recommended, but there is no evidence in the record that the surgery was performed.

CONCLUSIONS OF LAW AND OPINION

Aggravation Claim

Claimant argues that she is entitled to have her claim reopened on an aggravation basis because her condition has worsened from the time of the June 1985 stipulation. In order to establish a compensable aggravation of her knee condition, claimant must demonstrate that she has experienced a pathological or symptomatic exacerbation resulting in increased loss of use or function of her left knee since the 1985 stipulation. International Paper Co. v. Turner, 304 Or 354(1987), on rem 91 Or App 91(1988). The worsening may be temporary or permanent. Id.

The Referee concluded that the evidence failed to show a worsening of claimant's compensable condition. Furthermore, the Referee upheld the aggravation denial on the grounds that claimant had not provided evidence that any of her flare-ups had lasted more than fourteen days, or that she had required inpatient hospitalization. We agree that the aggravation claim fails, but we base our conclusion upon the following reasoning.

Claimant has not shown an exacerbation of her knee condition resulting in increased loss in use or function. She has been examined by at least six doctors, but none of them opine that her physical condition has worsened from the date of the June 1985 stipulation. Although an arthrogram in December 1987 suggested a possible lateral meniscus lesion, that diagnosis was never confirmed. Almost all of the doctors agree that claimant's

subjective complaints are not reflective of their objective findings.

Expert medical evidence is generally not required to prove an aggravation claim and claimant's subjective symptoms and limitations may be sufficient. Garbutt v. SAIF, 297 Or 148 (1984). We agree with the Referee's conclusion, however, that claimant was not reliable as to the self-assessment of her capacities or the disabling nature of her symptoms. The only evidence in the record of symptomatic worsening is claimant's testimony and the opinion of Dr. Dougan, her most recent physician, whose restrictions on claimant's work were based partially upon her complaints regarding her knee pain. Because we find claimant's subjective complaints and limitations unreliable, it follows that Dougan's opinion is likewise unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Under the circumstances, we therefore find that claimant has failed to prove an aggravation of her knee condition since the 1985 stipulation.

Penalties and Attorney Fees

In light of the conflicting evidence as to whether claimant's condition worsened since the 1985 stipulation, we do not find SAIF's denial to be unreasonable. Accordingly, penalties and attorney fees are not warranted. ORS 656.262(10).

ORDER

The Referee's order dated June 1, 1988 is affirmed.

DAWN E. LOWE, Claimant	WCB 87-16941
Peter O. Hansen, Claimant's Attorney	December 15, 1989
David B. Smith (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee Knapp's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a variety of conditions allegedly resulting from exposure to cigarette smoke at work; (2) declined to award interim compensation; and (3) declined to assess a penalty and associated attorney fee for failure to pay interim compensation. We reverse in part.

ISSUES

1. Compensability of a variety of conditions allegedly resulting from claimant's exposure to cigarette smoke at work.

2. Entitlement to interim compensation.

3. Entitlement to a penalty and associated attorney fee for failure to pay interim compensation.

FINDINGS OF FACT

Claimant worked for the employer as a financial accounting specialist. Her work station was on the fourth floor of an office building in Portland. In approximately June 1986,

she began to experience a number of symptoms including headaches, eye and throat irritation, chest congestion, a skin rash on her face and hot flashes. A number of her co-workers complained of some of the same symptoms. Claimant associated her symptoms with exposure to cigarette smoke at work and, in July 1986, sought medical evaluation and treatment from Dr. Wilcox, a family practitioner. Wilcox recommended that claimant be assigned to a nonsmoking area. The employer moved claimant's work station to another portion of the fourth floor, but her symptoms continued.

In July and August 1986, an indoor air quality investigation of the building where claimant worked was conducted by the Oregon State Health Division and the Multnomah County Health Department. The investigation revealed that the outside air intakes to the building's heating, ventilation and air conditioning system were closed and thus that the occupants of the building were breathing primarily recycled air. Air samples taken throughout the building revealed excessive levels of carbon dioxide. Other procedures revealed poor air circulation. In a report issued on October 1, 1986, the investigators attributed worker complaints of headaches and eye, throat and sinus irritation to excessive carbon dioxide levels and recommended a number of corrective measures including the prohibition of smoking in most areas of the building. These corrective measures were implemented by the employer in mid-October 1986.

On October 10, 1986, claimant sent a memo to her supervisor which stated that she was resigning her job, effective November 28, 1986. She gave the following reason for her resignation: "There are several environmental factors in force over which I have no control that are not in my best interest; such atmosphere is not conducive to maintaining a consistent level of efficiency." Claimant left work on November 28, 1986 and applied for unemployment compensation.

About a week after leaving work, claimant began to experience increasing chest congestion and eye irritation. She returned to Dr. Wilcox for treatment in December 1986. Dr. Wilcox prescribed medications and claimant subsequently complained of anosmia, the loss of her sense of smell. She was evaluated for this problem in April 1987 by Dr. O'Hollaren, an allergy specialist. Dr. O'Hollaren was unable to determine the cause of claimant's anosmia, but noted an enlargement of claimant's thyroid gland. He referred her to Dr. Cook, an endocrinology specialist for evaluation of this problem. Claimant had a history of thyroid enlargement dating back several decades. Dr. Cook was unable to determine the cause of the flare-up in April 1987, but did opine, and we find, that it was not related to claimant's former employment. He also indicated, and we find, that claimant's hot flashes were related to her thyroid condition.

Claimant's claim for unemployment compensation was initially rejected on the ground that she did not have "good cause" for leaving work. In June 1987, the Employment Appeals Board determined that the negative impact that cigarette smoke was having on claimant's health was good cause for leaving work and reversed the decision rejecting her claim for benefits. Two months later, on September 4, 1987, claimant filed a formal claim for workers' compensation with the employer. SAIF issued its denial of the claim on February 12, 1988. It paid no compensation pending its denial.

Claimant was evaluated for continuing chest congestion in November 1987 by Dr. Keppel, a pulmonary specialist. Dr. Keppel conducted lung function tests and diagnosed reactive airways disease, a hereditary condition characterized by hypersensitivity to nonspecific irritants. He opined, and we find, that this condition had not been caused by claimant's employment exposure to cigarette smoke, but that the condition had been irritated during the period of the exposure.

In January 1988, Dr. Paulsen, a psychiatrist, reported that claimant had a longstanding paranoid personality disorder and that claimant's work conditions "could have caused a worsening of her psychological status." Later in her report, she indicated that a number of nonjob-related factors also contributed to any worsening that may have occurred.

FINDINGS OF ULTIMATE FACT

Claimant's exposure to elevated levels of carbon dioxide and/or cigarette smoke at work was the major cause of her headaches, eye, nose and throat irritation and irritative bronchitis. Those problems required medical treatment.

Claimant left work on November 28, 1986 for reasons other than an inability to work.

CONCLUSIONS OF LAW

Compensability

Claimant claims a number of conditions, some on more than one theory.

We consider her claim for headaches and eye, nose and throat irritation first. Claimant sought medical treatment for those conditions from Dr. Wilcox. He related claimant's complaints to tobacco exposure and recommended that she be reassigned. Additionally, other employees working in the same environment suffered similar symptoms. Those symptoms were a typical reaction to the cigarette smoke and elevated carbon dioxide levels present at claimant's work place.

We find that the unrebutted evidence in this record causally relates claimant's headaches and eye, nose and throat irritation from June 1986 to November 28, 1986 in major part to her work.

We next consider claimant's respiratory condition. Two diagnoses related to pulmonary function have been made. One is reactive airways disease, which both Dr. O'Hallaren and Dr. Keppel felt preexisted claimant's work exposure. We have found that to be the case. Those doctors also appear to have agreed that claimant's work temporarily caused the symptomatic reaction associated with that disease. Because claimant's reactive airway disease preexisted her work exposure, a mere increase in symptoms is insufficient to prove compensability.

Claimant has failed to prove a worsening of her preexisting, underlying condition. Her reactive airways disease is, therefore, not compensable. Weller v. Union Carbide, 288 Or 27 (1979).

The second respiratory condition diagnosed was bronchitis. Dr. Keppel indicated that claimant suffered an irritative bronchitis while exposed to cigarette smoke at work and a resulting superinfection of that condition in December 1986, shortly after leaving work. At least the latter condition required medical treatment.

We conclude that the unrebutted evidence preponderates toward a finding that claimant's bronchitis in December 1986 was a consequence of, and materially related to, the irritative bronchitis she suffered at work. We find that latter condition to have been caused in major part by claimant's work exposure, based upon Dr. Keppel's unrebutted opinion. Claimant's irritative bronchitis and the bronchitis caused by infection in December 1986 are compensable.

We next consider claimant's claim for her thyroid condition. She argues that stress from work, including stress resulting from her work-related conditions and symptoms, was the major cause of a worsening of her preexisting thyroid condition. We agree with the Referee that claimant failed to prove any such causal relationship. There is no medical evidence of such a connection in this case, nor is there evidence to prove a worsening of that underlying, preexisting condition. Dr. Cook, who evaluated claimant on several occasions for her thyroid condition, felt that it was unrelated to her work. Claimant's thyroid condition is not compensable, nor are her associated hot flashes.

As to the next claimed condition, there is no probative evidence which attributes claimant's skin rash to work conditions or exposure. The rash did appear coincidentally with some of her other symptoms, but that fact, by itself, is not sufficient to establish compensability. See Bradshaw v. SAIF, 69 Or App 587, 589-90 & n.2 (1984); Edwards v. SAIF, 30 Or App 21, 24, rev den 279 Or 301 (1977).

Finally, we consider claimant's psychological claim. The record regarding her personality disorder is poorly developed. Dr. Paulsen's January 1988 report seems to indicate that she had been treating claimant for a number of years for what she characterized as "paranoid personality disorder." This was confirmed in claimant's testimony. At one point in her report, Paulsen stated that claimant's work conditions "could have caused a worsening of her psychological status." She went on to state, however, that claimant probably misperceived many events at work and that "her relationships with others outside of the work environment and her home have been stress producing in the past and have been part of the progression of her personality disorder." She then concluded her opinion with the comment, "From the material I reviewed, I cannot state that the work exposure alone caused the need for time off work as of November 28, 1986." (Ex. 11BB).

The only other evidence regarding a connection between claimant's work activity or exposure and her psychological condition is in a report by Dr. Keppel, the pulmonary specialist. He stated:

> "It is my opinion that the stress created at her work environment both due to the direct

effect on her lungs as well as the stress of coping with the subsequent symptomatology would put her at increased psychological disadvantage. In addition, she has a background of paranoid personality with difficulty in dealing with such situations. Therefore, I feel that the work exposure was the major cause of her ongoing need of subsequent medical care. . . . It would also be my opinion that the underlying stress was materially worsened based on her continued psychologic difficulty in dealing with her medical symptoms."
(Ex. 11C-1 & 2).

The above evidence is sufficient to support the conclusion that claimant has a paranoid personality disorder. It is clear from Dr. Paulsen's report, however, that the disorder was not caused by claimant's work activity or exposure. Paulsen is only able to say that the disorder may have been worsened and that work events and conditions, a substantial portion of which were probably misperceived, may have contributed in some unspecified degree to the worsening. Such speculative and vague comments are not sufficient to establish a compensable mental stress claim. See McGarrah v. SAIF, 296 Or 145, 165-66 (1983); Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Dr. Keppel's comments take a different and somewhat confusing tack, but are similarly inconclusive. He stated that claimant's respiratory symptoms caused her stress and that her preexisting personality disorder put her at a "psychological disadvantage" in coping with that stress. He did not state that the stress of coping with her respiratory symptoms resulted in either a psychological or symptomatic worsening of her personality disorder or provide information sufficient for us to reach such a conclusion. Neither does it appear that he was aware of the off-work relationships which Dr. Paulsen, claimant's treating psychiatrist, implicated as the cause of past progression of claimant's personality disorder. Without a complete history, Dr. Keppel's psychiatric opinion is of little value. We conclude, therefore, that claimant has failed to establish a compensable psychological condition.

Interim Compensation

A claimant is entitled to temporary disability compensation pending acceptance or denial of a claim for a disabling injury if she "leaves work" within the meaning of ORS 656.210. Bono v. SAIF, 298 Or 405, 408-10 (1984); see also Jones v. Emanuel Hospital, 280 Or 147, 150-52 (1977). Such compensation, called "interim compensation" for convenience, is due beginning 14 days after the date upon which the employer or its insurer receives notice or knowledge of the claimant's claim. ORS 656.262(4).

Claimant resigned her employment on November 28, 1986 because of her concern that her exposure to cigarette smoke at work was adversely affecting her health. The reasonableness of her decision is not in issue. At the time that claimant left work, however, she was still performing her regular work at full capacity. It is unclear whether the previously offensive conditions still existed when she left work in late November

1986. At that time, therefore, she was not disabled and did not "leave work" within the meaning of either ORS 656.210 or 656.212. See Weyerhaeuser v. Bergstrom, 77 Or App 425 (1986).

The record is unclear regarding whether claimant became disabled at any point thereafter. None of the medical reports issued during the period between the date upon which she left work and the date of SAIF's denial indicate that she was unable to work because of any of the claimed conditions. Her successful claim for unemployment compensation for the period after she left work suggests that she was able to work. See ORS 657.155; Wells v. Pete Walker's Auto Body, 86 Or App 739, 741-42 (1987). On this record, we find that SAIF never received a claim for a disabling condition and conclude that claimant was not entitled to interim compensation for that reason. Weyerhaeuser v. Bergstrom, supra, 77 Or App at 427-28; Nix v. SAIF, 80 Or App 656, 659-60, rev den 302 Or 158 (1986).

Penalty and Attorney Fee for Failure to Pay Interim Compensation

A carrier is liable for a penalty and associated attorney fee for unreasonably delaying or refusing to pay compensation due. ORS 656.262(10), 656.382(1). SAIF's failure or refusal to pay interim compensation in the present case was reasonable because it never received a claim for a condition which entitled claimant to such compensation. No penalty or associated attorney fee, therefore, will be assessed.

ORDER

The Referee's order, dated March 28, 1988, is reversed in part. That portion of the Referee's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for headaches, and the eye, nose, throat and bronchitis experienced by claimant between June 1986 and November 28, 1986, and the bronchitis claimant experienced in December 1986, is reversed. The case is remanded to SAIF for acceptance and processing of claimant's claims for those conditions. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,000 for services rendered at the hearing level and $500 for services rendered on Board review on the compensability issue, to be paid by the SAIF Corporation.

TIM L. MORLOCK, Claimant
Barbara A. Brainard (SAIF), Defense Attorney

WCB 88-02454
December 15, 1989
Order on Review (Remanding)

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Thye's order that dismissed his request for hearing. On review, the issue is dismissal. We vacate and remand.

FINDINGS OF FACT

Prior to the hearing, claimant's attorney wrote a letter to the Referee indicating that claimant's employer had threatened to fire him if he attended the hearing. Wishing to avoid being fired, claimant informed his attorney that he would not attend the hearing. Claimant understood that failing to appear at the hearing would result in a dismissal of his hearing request.

A few days later, the Referee entered an Order of Dismissal, dated May 18, 1989. The dismissal order stated: "The Request for hearing in this matter has been withdrawn. Accordingly, the matter is dismissed."

Shortly thereafter, claimant's attorney apparently withdrew his representation. On June 6, 1989, claimant sent the following handwritten note addressed to the Workers' Compensation Board:

> "Dear Sirs,
> I would like to request of my case a new review.
> I was unable to attend the last date due to my work schedule. Please issue me a new hearing date."

CONCLUSIONS OF LAW

The Hearings Division retains jurisdiction over a request for hearing for 30 days following the issuance of an Order of Dismissal, unless a request for Board review is filed prior to that time. See ORS 656.289(3).

Given that claimant was apparently no longer represented at the time he filed his letter of June 6, 1989, and that 30 days had not elapsed following the issuance of Order of Dismissal, we conclude that the Referee should have ruled on claimant's request for postponement of the original hearing and reinstatement of his hearing request. See Mark R. Luthy, 41 Van Natta 2131 (November 21, 1989). Accordingly, we remand this case to the Referee.

ORDER

The Referee's order, dated May 18, 1989, is vacated. This case is remanded to Referee Thye with instructions to entertain claimant's request for reinstatement. If the Referee should determine that claimant's hearing request should be reinstated, then claimant's letter of June 6, 1989, should be submitted to the Hearings Division for processing as a request for hearing.

JAMES L. SWINDLER, Claimant	Own Motion 88-0156M
Black, et al., Claimant's Attorneys	December 15, 1989
	Own Motion Determination

The insurer voluntarily reopened claimant's claim for a worsened condition related to his industrial injury of November 16, 1981. The insurer originally closed claimant's claim by Notice of Closure on October 6, 1989, but later rescinded its closure notice. The insurer now submits the claim to the Board for closure.

Claimant requests review of the insurer's October 6, 1989, Notice of Closure or, alternatively, requests that the Board refer this matter for consolidation with his pending request for hearing in WCB Case Nos. 89-23922 & 89-23923 on the question of whether his current condition represents a worsening of his 1981 industrial injury or, rather, a new injury. In light of the insurer's rescission of its closure notice, we interpret claimant's review request as a challenge to the insurer's request for Board closure at this time.

Turning to claimant's referral request, the Board declines to grant the request. We are persuaded that claimant is medically stationary and that closure of his claim is now appropriate. Although the Board often postpones action on own motion requests for claim reopening when there is pending litigation bearing a direct relationship to own motion issues, the Board rarely, if ever, postpones action on own motion requests for closure in cases in which temporary disability benefits would continue to be paid, perhaps indefinitely. The possibility of a large unrecoverbale overpayment renders that type of Board action inappropriate. Moreover, Board closure at this time would not preclude claimant from contending at hearing that more recent work activities independently contributed to his current condition and, hence, that benefits should be provided under a new injury claim. Should claimant prevail at hearing, any adjustment of benefits between claims can be ordered pursuant to Fischer v. SAIF, 76 Or App 656 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Claimant's request for referral of this own motion matter to the Hearings Division is denied.

Claimant's claim is closed with an award of temporary total disability from May 5, 1987, through September 22, 1989, less time worked. Claimant is awarded 38 percent (121.6 degrees) unscheduled permanent disability. This award is in lieu of, not in addition to, previous awards of permanent disability for this injury. Deduction of overpaid temporary disability, if any, from unpaid permanent disability is approved.

IT IS SO ORDERED.

ALLEN TEAGLE, Claimant	WCB 87-12533
Wilbur C. Smith, Jr., Claimant's Attorney	December 15, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of those portions of Referee Peterson's order which upheld the insurer's denial of claimant's claim for a left arm condition and a heart attack. On review, the issues are compensability of the heart attack and left arm condition. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

ULTIMATE FINDING OF FACT

As a result of the July 14, 1987, motor vehicle accident, which occurred while claimant was in the course and scope of his employment, claimant received medical services for his left arm and shoulder.

CONCLUSIONS OF LAW

We adopt the Referee's conclusions, which held that claimant's heart attack was not compensable. We reverse with respect to the left arm claim, finding it compensable.

To establish a compensable injury under ORS 656.005(7)(a), claimant must show that he suffered an injury arising out of and in the course of employment, which required medical services or resulted in disability or death. Here, the

Referee acknowledged that claimant had injured his left elbow and shoulder in the accident. However, finding no evidence that he required medical services or suffered disability, the Referee upheld the insurer's denial of the left shoulder claim. We disagree.

Claimant suffered a contusion and was in sufficient elbow and shoulder pain to require medical care. Specifically, while at the hospital, claimant underwent an examination and x-ray of the shoulder/elbow region.

Pursuant to ORS 656.005(7)(a), claimant has suffered a compensable injury. Inasmuch as claimant required medical services for his left arm and shoulder as a result of the July 1987 motor vehicle accident, that portion of the claim is compensable.

ORDER

The Referee's order dated April 25, 1988, is reversed in part and affirmed in part. That portion of the insurer's denial which denied claimant's left arm and shoulder 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 this issue, claimant's attorney is awarded a reasonable fee of $1,750 to be paid by the insurer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,196, is approved.

ARNOLD G. WHEELER, Claimant	Own Motion 87-0276M
Kilpatricks & Pope, Claimant's Attorneys	December 15, 1989
SAIF Corp Legal, Defense Attorney	Own Motion Order

Claimant was granted permanent total disability in 1968. On May 7, 1987, the SAIF Corporation requested that the Board exercise its own motion authority under ORS 656.278 and reevaluate claimant's permanent total disability award. By Interim Own Motion Order dated June 16, 1987, we referred the matter for hearing and instructed the Referee to take additional evidence concerning claimant's entitlement to an award of permanent total disability benefits. We further instructed the Referee to forward to us the entire record, along with his proposed findings and recommendations regarding SAIF's request. The Referee has forwarded to the Board his proposed findings and recommendations. However, we conclude that we lack jurisdiction to consider SAIF's request for reevaluation of claimant's permanent total disability award.

The current version of ORS 656.278, which became effective January 1, 1988, does not authorize the Board to modify prior awards of permanent disability benefits on its own motion. See Andy Webb, 40 Van Natta 586 (1988); Orville D. Shipman, 40 Van Natta 537 (1988). Although Webb and Shipman each involved a claimant's request for additional permanent disability benefits, those decisions are equally applicable to an insurer's request for a reduction in permanent disability benefits. The current version of ORS 656.278 and the rules promulgated thereunder govern all own motion requests for compensation that were pending on January 1, 1988, but not reopened as of that date. OAR 438-12-018. Here, although SAIF's request for a reevaluation of claimant's permanent disability was pending before the Board on January 1, 1988, claimant's claim remained closed on that date. Hence, SAIF's request must be processed under the current version of ORS 656.278. See id; Donald

S. Wincer, 40 Van Natta 1196 (1988). Because we are no longer authorized to modify prior awards of permanent disability, we must deny SAIF's request for own motion relief for lack of jurisdiction.

Citing Judith Moore, 40 Van Natta 755 (June 16, 1988), SAIF argues that, because the Board issued an interim order prior to January 1, 1988, referring this matter for hearing and further evidence taking, the Board now retains jurisdiction to reevaluate permanent disability under former ORS 656.278. We disagree. The issuance of our interim order in 1987 had no effect on our jurisdiction to modify prior awards of permanent disability. Moore is not to the contrary. In Moore claimant requested own motion reopening of her claim for an alleged worsening of her 1974 industrial injury. The Board deferred action on her request pending the outcome of a hearing on the issue of whether claimant's then-current condition was compensable. The Referee ultimately concluded that claimant's condition was not compensably related to the 1974 injury. Based on that conclusion, which we affirmed on Board review, we denied claimant's request for own motion relief. The parties in Moore did not request an evaluation of permanent disability; consequently, the Board's jurisdiction to evaluate permanent disability was never at issue in that case. Hence, Moore does not apply here.

Accordingly, SAIF's request for own motion relief is denied.

IT IS SO ORDERED.

CRISTOBAL R. ALMARAZ, Claimant
Black, et al., Claimant's Attorneys
John E. Snarskis, Defense Attorney
Cowling & Heysell, Defense Attorneys

WCB 86-08236 & 86-08237
December 18, 1989
Order on Review

Reviewed by Board Members Nichols and Brittingham.

Liberty Northwest Insurance Corporation requests review of Referee Brown's order that: (1) set aside its denial of responsibility for claimant's low back claim; (2) upheld Industrial Indemnity's denial of compensability and responsibility for the same condition; and (3) awarded claimant's attorney an assessed fee of $1,500 for services at hearing. We reverse.

ISSUES

1. Whether Industrial Indemnity's denial became final as a result of claimant's untimely request for hearing.

2. Responsibility between insurers for claimant's low back condition.

3. Attorney fees.

FINDINGS OF FACT

Claimant compensably injured his thoracic spine in September 1983. Industrial Indemnity accepted the claim and benefits were paid. Thereafter, claimant received chiropractic treatment from Dr. Wehinger throughout the thoracic spine. Although the upper thoracic area was most affected by the 1983 injury, claimant also complained of symptoms and received treatment down to the tenth thoracic vertebra. He was ultimately declared medically stationary by Wehinger and the claim was closed

with no award of permanent disability in March 1985. Claimant's thoracic spine remained intermittently symptomatic after claim closure.

Claimant's employer changed insurers from Industrial Indemnity to Liberty Northwest Insurance Corporation before January 1, 1986. On January 2, 1986, claimant experienced increased thoracic pain after lifting boards at work. He returned to Dr. Wehinger, complaining of pain primarily in the T10 area. Wehinger recommended increased chiropractic treatment. Claimant filed a claim for aggravation with Industrial Indemnity, which issued a denial based on responsibility on February 21, 1986. Claimant did not file a request for hearing within 60 days of the denial and he did not show good cause for failure to do so. He filed a new injury claim with Liberty Northwest, which issued a denial of responsibility on June 5, 1986. Claimant timely filed a request for hearing from that denial. Liberty Northwest thereafter requested a .307 order, which was denied because of Industrial Indemnity's assertion of a timeliness defense.

Claimant was examined by Dr. Hearns in March 1986. Claimant made no mention of a new injury and attributed his then-current symptoms to the 1983 injury.

Claimant's 1986 incident did not independently contribute to a worsening of his underlying low back condition.

The compensability of claimant's low back claim was at issue at hearing by virtue of Industrial Indemnity's assertion of the defense of timeliness.

CONCLUSIONS OF LAW

Timeliness of Hearing Request/Responsibility Between Insurers

This case involves successive injuries in which claimant was injured on one job, was temporarily disabled, returned to work and experienced a second period of disability following another work-related incident. In Hensel Phelps Const. Co. v. Mirich, 81 Or App 290 (1986), the court held that in successive injury cases of this type liability remains with the first employer absent a showing that the later employment independently contributed to a worsening of the claimant's underlying condition. Increased treatment and/or worsened symptoms alone do not shift liability.

The Referee upheld Industrial Indemnity's aggravation denial on the basis that claimant had failed to timely request a hearing. Claimant takes no position with regard to that issue on review. We find no reason to disturb the Referee's holding in that regard.

We disagree with the Referee, however, that Liberty Northwest is responsible for claimant's current condition. The Referee based his conclusion on the testimony of Dr. Wehinger, who opined at hearing that claimant's second work incident caused new and worsened symptoms at T10. Dr. Wehinger also opined that the second incident created a greater need for treatment. As noted above, a need for increased treatment and/or increased symptoms alone will not shift responsibility away from the first employer, absent a persuasive showing that the second incident contributed to an actual worsening of the underlying condition. Mirich, supra.

The purported "worsened condition" in this case is apparently the alleged presence of symptoms at a new level of claimant's thoracic spine. Dr. Wehinger testified that he treated claimant's T5-7 area following the first incident, while the second injury necessitated treatment at T10. Wehinger's chart notes, however, demonstrate that he treated claimant's T10 area following the first incident, as well, albeit for a lesser period of time. Indeed, Wehinger diagnosed a "chronic myofascial syndrome" at T8-10 on April 1, 1985, a full nine months prior to the second incident.

From our view of this record, we conclude that claimant injured his thoracic spine down to T10 at the time of the 1983 incident. He was treated at that level following the first incident and remained intermittently symptomatic there up to the time of the 1986 incident. That incident necessitated increased treatment at T10, but there is no persuasive evidence that the second injury independently contributed to a worsening of claimant's underlying mid-back condition. Without such evidence, there is no shift of liability. Liberty Northwest's denial should be upheld.

Attorney Fee

Our decision on the compensability/responsibility issue renders this question moot.

ORDER

The Referee's order, dated July 29, 1987, is reversed in part and affirmed in part. Those portions of the order that set aside Liberty Northwest Insurance Corporation's denial and awarded an insurer-paid attorney fee are reversed. The remainder of the order is affirmed. A client-paid fee not to exceed $573, payable by Liberty Northwest to its counsel, is approved.

SAMMIE J. MOORE, Claimant	WCB 85-02704
Kenneth D. Peterson, Jr., Claimant's Attorney	December 18, 1989
Roberts, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Cushing and Myers.

The attorney for the deceased claimant requests review of Referee Shebley's order of dismissal. The sole issue on review is whether the Hearings Division or the Board had jurisdiction to consider claimant's case. We affirm.

FINDING OF FACT

This matter was heard in April 1986 by Referee Shebley. The issue was the compensability of surgery. Referee Shebley found the surgery compensable. The employer requested Board review. Claimant then underwent surgery. Before the Board could decide the employer's request for review, claimant died of causes unrelated to the compensable claim. On June 10, 1988, the Board remanded to Referee Shebley to consider evidence about the surgery and about claimant's death.

On remand, the employer moved to dismiss claimant's request for hearing on the grounds that claimant was deceased and had no beneficiaries under ORS 656.204 who had a right under ORS 656.218(3) to pursue the case. Claimant did not respond to

the motion to dismiss. On July 11, 1988, Referee Shebley dismissed claimant's request for hearing.

The attorney requested review of Referee Shebley's order. The attorney concedes that claimant has no heirs.

CONCLUSIONS AND OPINION

ORS 656.218(3) states:

> "If the worker has filed a request for a hearing pursuant to ORS 656.283 and death occurs prior to the final disposition of the request, the person described in subsection (5) of this section shall be entitled to pursue the matter to final determination as to all issues presented by the request for hearing."

Subsection (5) refers, in turn, to those persons entitled to death benefits for fatal injuries as defined in ORS 656.204. Those entitled to death benefits under ORS 656.204 are spouses, children under 18, dependents and parents (if the claimant is under 21 years old at the time of death).

From claimant's attorney's concession that claimant left no heirs we infer that claimant had no surviving spouse, no children under 18 and no dependents. Claimant was over 21 years old at the time of death.

Accordingly, we conclude that there is no one who has a statutory right to pursue claimant's request for hearing. The attorney is not such a person, and is, therefore, without standing. The Referee was correct to dismiss for lack of jurisdiction.

ORDER

The Referee's order, dated July 11, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $1,173.50.

DEBORAH L. PEARSON, Claimant
Malagon, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-06095
December 18, 1989
Order on Review

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Higashi's order that: (1) declined to leave the record open for the purposes of allowing claimant to depose her treating chiropractor; and (2) upheld the self-insured employer's medical services denial. On review, the issues are evidentiary and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's findings with the exception of the finding that the October 23, 1983, automobile accident was "not related to her work." In addition, we make the following additional findings.

The October, 1983, automobile accident occurred while claimant was traveling to Dr. Hebert's office. Hebert, a chiropractor, was treating claimant for the March, 1983, compensable injury.

The medical services denied by the employer in its June, 1987, denial, are materially related to injuries claimant sustained in the October, 1983, automobile accident.

CONCLUSIONS OF LAW

Evidentiary Issue

The Referee declined to leave the record open for the purposes of allowing claimant to depose Hebert. We agree.

Former OAR 438-07-005(4), in effect at the time of the hearing, provided:

> "[T]he referee may in his or her discretion allow admission of additional medical reports or other documentary evidence not filed as required by (3) above. In exercising this discretion, the referee shall determine if good cause has been shown for failure to file within the prescribed time limits as well as factors of surprise or prejudice to the other parties."

Here, the Referee asked claimant's counsel why Hebert had not been deposed prior to the hearing. Claimant's counsel replied that she did not know. Under such circumstances, we agree with the Referee that claimant did not show good cause to warrant leaving the record open.

Compensability

The Referee concluded that claimant had not proven compensability. We disagree.

Res Judicata

On review, the employer argues that the medical bills it denied in June, 1987, are not compensable by operation of a July, 1986, stipulation, which stated that medical bills it denied in February, 1986, were not compensable. We disagree.

Claimant sustained a compensable neck and back injury in March, 1983. She sought treatment from Hebert. While driving to Hebert's office in October, 1983, she was involved in an automobile accident. In February, 1986, the employer denied all medical bills that had been submitted by way of an October 29, 1985, letter, from claimant's attorney. The reasoning behind the employer's denial was that the submitted medical billings were directly related to the October, 1983, automobile accident. In July, 1986, claimant entered into a Disputed Claim Settlement ("DCS"), which settled her request for hearing concerning the compensability of the medical billings she submitted in October, 1985. By way of the DCS, claimant accepted a cash settlement in exchange for stipulating that the billings she submitted in October, 1985, were not compensable.

The doctrine of res judicata precludes relitigation of claims or issues previously adjudicated in a prior proceeding. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Here, res judicata does not operate to procedurally bar claimant from litigating the compensability of her current medical services. Neither the current medical services claim nor the current medical services issue have been previously adjudicated in a prior proceeding. Rather, claimant merely entered into a written DCS disposing of contested medical billings.

Accordingly, the Referee was correct insofar as he did not apply the doctrine of res judicata to this case.

Merits of Compensability

Given the facts of this case, the Referee applied an incorrect legal test in analyzing the merits of the compensability issue. That is, he stated: "[C]laimant must show that the treatments were related to the accepted [March, 1983,] condition and not the [October, 1983,] automobile accident." (Emphasis added).

Here, the parties do not dispute that the denied medical treatment is for residuals of the October, 1983, automobile accident. Claimant argues, however, that because the accident occurred while she was en route to an appointment with Hebert for chiropractic treatment of her compensable March, 1983, injury, she is entitled to treatment for the residuals arising out of the accident. We agree. In Fenton v. SAIF, 87 Or App 78, 83 (1987), the court held that: "[W]hen a worker is injured in an accident which occurs during a trip to see a physician for treatment of a compensable injury, the new injury also is compensable." The employer does not argue that Fenton is not dispositive of the compensability question, if the fact finder is not persuaded by its res judicata argument.

We have concluded above that the doctrine of res judicata does not apply to this case. In addition, we conclude that there is no meaningful distinction between Fenton and the case at bar. Fenton is, therefore, dispositive of the compensability question.

Accordingly, we conclude that claimant has proven that her current medical services are compensable.

ORDER

The Referee's order, dated November 27, 1987, is reversed in part and affirmed in part. That portion of the order that upheld the employer's denial is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing according to law. All remaining portions of the Referee's order are affirmed. For services at the hearing and on Board review, claimant's attorney is awarded reasonable attorney fees of $1,200 and $900 respectively, for a total fee of $2,100, to be paid by the employer. The Board approves a client-paid fee, not to exceed $603.50.

Claimant requests reconsideration of that portion of our November 20, 1989 Order on Review that declined to award a carrier-paid attorney fee for services rendered at hearing and on review for successfully prevailing against the self-insured employer's denial of claimant's "new injury" claims for a neck, right shoulder and low back condition. We declined to award an attorney fee because claimant's counsel had not filed a statement of services. Enclosing a statement of services for his counsel's efforts at hearing and on Board review, claimant seeks an attorney fee pursuant to ORS 656.386(1). The request is denied for lack of jurisdiction.

FINDINGS OF FACT AND ULTIMATE FACT

On November 20, 1989, the Board issued an Order on Review. In that order, the Board reversed a Referee's order which had upheld the employer's denial of claimant's "new injury" claims. The Board's order further stated that since no statement of services had been received from claimant's counsel, no assessed fee for counsel's services at hearing or on review could be awarded.

On December 7, 1989, the employer appealed the Board's order to the Court of Appeals. On December 12, 1989, claimant's attorney submitted a statement of services and sought reconsideration of the Board's November 20, 1989 order.

CONCLUSIONS OF LAW AND OPINION

Pursuant to our November 20, 1989 order, claimant prevailed against an order or decision denying his claim for compensation. Consequently, we reasoned that claimant was entitled to a carrier-paid attorney fee. ORS 656.386(1). However, because no statement of services had been submitted, we held that we were unable to award a fee. See OAR 438-15-010(5).

Submitting a statement of services, claimant's counsel seeks reconsideration of that portion of our order which declined to award a carrier-paid fee. Inasmuch as our order has been appealed, this submission raises the question of whether we have jurisdiction to address claimant's request for an attorney fee.

We have previously concluded that, in certain circumstances, we retain jurisdiction to consider a request for an attorney fee even after the order on the merits has been appealed. See Franklin Brown, 40 Van Natta 786 (1988), rev'd on other grounds Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989). In order to retain jurisdiction over the attorney fee request, our prior order must not have addressed either the entitlement to, or the amount of, an attorney fee. Gabino R. Orozco, 41 Van Natta 599, 775 (1989).

Here, our November 20, 1989 order addressed claimant's counsel's entitlement to a carrier-paid fee. Since that order has been appealed to the Court of Appeals, we lack jurisdiction to consider the attorney fee request.

We have also held that it is possible to withdraw an order for further consideration after the filing of a petition for

judicial review. Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987). The merits of this case are presently pending before the court and, in the event claimant ultimately prevails, the court has the authority to either award a carrier-paid fee or return the case to us for such an award. We, therefore, decline to withdraw our November 20, 1989 order.

Accordingly, claimant's request for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

SAMMY L. TURNER, Claimant	WCB 89-09215
Roger J. Leo, Claimant's Attorney	December 18, 1989
C. Douglas Oliver (SAIF), Defense Attorney	Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the SAIF Corporation's request for review on the ground that it did not file an appellant's brief within the time allowed by the briefing schedule. The motion is denied.

FINDINGS OF FACT

The SAIF Corporation requested Board review of the Referee's order within 30 days of its issuance. Copies of the hearing transcript were distributed to the parties on November 8, 1989. At that time, a briefing schedule was implemented.

SAIF was notified that its appellant's brief was due November 22, 1989. Claimant was advised that its respondent's brief was due 14 days after the date of mailing of SAIF's appellant's brief. On December 7, 1989, the Board received claimant's motion to dismiss SAIF's request for review, accompanied by a respondent's brief.

CONCLUSIONS OF LAW

In essence, claimant contends that we lack jurisdiction to consider SAIF's request for review because it 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 is denied.

We further reject claimant's respondent's brief as untimely. A respondent's brief is due 14 days from the date of mailing of an appellant's brief. OAR 438-11-020(2). The Board's rules may be waived if the requesting party files a motion seeking such waiver and the Board finds that extraordinary circumstances beyond the control of the requesting party exist that would justify the waiver of its rules. OAR 438-11-030.

Here, claimant's brief was neither accompanied by a motion for waiver of the Board's rules nor a statement of facts suggesting that extraordinary circumstances exist for his failure to timely submit his respondent's brief. Moreover, assuming that claimant had submitted a motion and a statement of facts, we would not consider the present circumstances extraordinary, particularly

when claimant could either have contacted the Board to determine whether an appellant's brief had been submitted or timely sought an extension within which to submit his brief based on SAIF's failure to timely submit a brief. See OAR 438-11-020(3).

Inasmuch as no briefs have been timely submitted, this case shall be docketed for review.

IT IS SO ORDERED.

SHEILA A. CRESS, Claimant
Malagon, et al., Claimant's Attorneys
Kate Donnelly (SAIF), Defense Attorney
Acker, Underwood, et al., Defense Attorneys

WCB 86-15248 & 87-14036
December 19, 1989
Order on Reconsideration

The self-insured employer has requested reconsideration of our November 30, 1989, Order on Review, which affirmed the Referee's order finding that claimant had proven "good cause" for filing her request for hearing beyond the 60-day period of ORS 656.319(1)(a). Specifically, the employer argues that we used inartful language in our order and that our reliance on the case of Jeffrey A. Domber, 41 Van Natta 1236 (1989) was "misplaced."

After reconsidering this case in light of the employer's arguments, we agree that our reliance on Jeffrey A. Domber was misplaced. In that case, unlike here, denial letters were mailed to an address at which the worker did not reside. A case more nearly on point is James G. Adams, 41 Van Natta 1234 (1989), wherein the Board held that the worker had established "good cause" for untimely filing his request for hearing.

In any event, the issue before us is whether claimant has proven "good cause" to excuse her late filing. See ORS 656.319(1)(b). "Good cause" has been defined as "mistake, inadvertence, surprise or excusable neglect" as those terms are used in former ORS 18.160 and ORCP 71B(1). Brown v. EBI Companies, 289 Or 455 (1980); Sekermestrovich v. SAIF, 280 Or 723 (1977).

Here, claimant's reason for failing to file in a timely manner was the lack of personal notice of the employer's denial. That lack of personal notice resulted from a failure of either her mother or sister, one of whom accepted delivery of the employer's denial, to deliver that notice to her. The Referee in the case at bar correctly observed that in Brown, the Court held that the mistake or neglect of an employee, not charged with responsibility for recognizing and correctly handling a crucial legal notice, could constitute "good cause" under ORS 656.319(1)(b). 280 Or at 460. After examining that issue on remand, Rhonda Brown, 30 Van Natta 354 (1980), the Board concluded that the worker had proven "good cause" to excuse her late filing.

Similarly, in the case at bar, we conclude that claimant had "good cause" for her untimely request for hearing. Her late filing resulted from the neglect or mistake of a family member not charged with responsibility for recognizing and properly handling the employer's denial.

Accordingly, our November 30, 1989, order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 30, 1989, order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

EMIL KORDON, Claimant
Malagon, et al., Claimant's Attorneys
Pamela Schultz (SAIF), Defense Attorney

WCB 86-01089
December 19, 1989
Second Order on Remand

Claimant has requested reconsideration of our November 16, 1989 Interim Order on Remand that declined to award an assessed fee for services rendered at the Board level for successfully prevailing against the SAIF Corporation's contention in its respondent's brief that claimant's unscheduled permanent disability award, as granted by the Referee, should be reduced. We declined to award an attorney fee because claimant's counsel had not filed a statement of services. Enclosing a statement of services for his counsel's efforts, claimant seeks an attorney fee.

To begin, we reiterate that our authority on remand is limited to a determination of a reasonable attorney fee for claimant's successful defense against SAIF's contention in its respondent's brief on Board review that the Referee's award of permanent disability should be reduced. In this regard, we note that claimant finally prevailed on this issue before remand to the Board, not after remand. Consequently, assuming without deciding that claimant would be entitled to an attorney fee award for services rendered at the appellate level in prevailing on his contention that he was entitled to an attorney fee on Board review, we lack authority on remand to award attorney fees for services before such prior forums. See ORS 656.388(1); Aguiar v. J.R. Simplot Company, 94 Or App 658 (1989).

We proceed with our determination. After review of the statements of services and considering the factors set forth in OAR 438-15-010(6), we award a reasonable assessed fee for services at the Board level of $500, to be paid by SAIF. In arriving at this determination, we note that the extent of claimant's counsel's services on Board review in defense of the Referee's permanent disability award consists of approximately one-half page in his reply brief.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 16, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

PIEDAD ZARATE, Claimant
Michael B. Dye, Claimant's Attorney
Stafford J. Hazelett, Defense Attorney

WCB 87-09512
December 19, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Borcher's order which: (1) upheld the insurer's denial of an aggravation claim of an accepted injury; (2) upheld the insurer's partial denial of a cervical condition; and (3) upheld the insurer's denial of chiropractic treatment as not being reasonable and necessary. On review, the issues are compensability of an aggravation claim, compensability of the cervical condition and compensability of chiropractic care. The insurer moves to strike claimant's reply brief because claimant did not timely serve the insurer with a copy of the brief.

We deny the insurer's motion to strike. There is no showing that the insurer was in any way prejudiced by receiving the copy of the reply brief late.

With her brief, claimant submitted an Opinion and Order from a different case and an article from a medical textbook. We decline to take official notice of the Opinion and Order because it is without relevance to this case. We decline to take administrative notice of the article because we conclude that it is offered to establish facts which the insurer is given no opportunity to contest, cross-examine or refute. It is not an appropriate matter for official notice. See Groshong v. Montgomery Ward Co., 73 Or App 403, 408 (1985).

We adopt the Referee's findings with the following addition. The insurer's denial purports to deny future chiropractic care.

We adopt the Referee's conclusion with the following supplementation. Insofar as the denial purports to deny future chiropractic care, it is impermissible. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Accordingly, we reverse that portion of the Referee's order which upheld the insurer's denial of future chiropractic treatments.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review concerning the denial of future chiropractic care. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated July 20, 1988, is affirmed in part and reversed in part. Those portions of the Referee's order which upheld the denial of future chiropractic treatments are reversed. The Referee's order is affirmed in all other respects.

ALICE M. GENTRY, Claimant	Own Motion 88-0195M
Ackerman, et al., Claimant's Attorneys	December 20, 1989
SAIF Corp Legal, Defense Attorney	Own Motion Order on Reconsideration

Claimant requests reconsideration of our October 27, 1989, Own Motion Denying Review of Self-Closure that denied her request for review of the insurer's Notice of Closure as being untimely. We abated our October 27, 1989 order on December 6, 1989.

Claimant requested review of a Notice of Closure dated October 3, 1988. Claimant's request was sent by certified mail on December 2, 1988, but received by the Board December 8, 1988. Claimant contends that, because the request for review was mailed by certified mail on December 2, 1988, the final day of the appeal period, the request was timely. We disagree.

OAR 438-12-060(1), which governs Board review of carrier closures, states: "The request must be received by the Board within 60 days of the mailing date of the insurer claim closure to be considered." Here, even though claimant's review request was mailed on the 60th day of the appeal period, it was not actually received by the Board until December 8, 1988, six days after the appeal period expired. Therefore, claimant's request was untimely, and the closure is final by law.

Accordingly, we adhere to and republish our October 27, 1989, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

SHARON Y. KELLY, Claimant
Karen M. Werner, Claimant's Attorney
Alice M. Bartelt, Defense Attorney

WCB 88-04153
December 20, 1989
Order on Review

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Seifert's order which upheld the insurer's denial of her occupational disease claim for a stress condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer in December 1986, as an insurance salesperson. Prior to that time, she had worked as an insurance salesperson for approximately 12 years. She sought work with the employer in order to be trained in the areas of securities and major medical coverage. While working at the employer, her sales manager was Bruce Bielke and the district manager was Randy Verburg.

In early 1987, claimant began experiencing difficulty with Bielke, her immediate supervisor. He was supposed to teach claimant the paperwork related to the employer's business, but he was unfamiliar with the procedure and was unable to instruct her. She also noticed that he was signing client's names on applications and was taking calls and messages from her clients without informing her. Bielke also began calling claimant at home, concerning business matters, during her scheduled days away from the office. As a result of these calls, claimant purchased an answering machine to screen calls at her home.

On several occasions, Bielke would meet with Verburg and immediately following these meetings, claimant would be called into Verburg's office and verbally reprimanded. Claimant requested a transfer to another office in the same general area, but her request was denied by Verburg. In June 1987, claimant joined the union and filed more than 20 grievances which were denied by the employer. In September 1987, Verburg was replaced as district manager by Jeff Schmitt.

In December 1987, claimant sought treatment for anxiety, depression and sleep disturbance from Dr. Worthington, psychologist. Dr. Worthington authorized time loss commencing December 8, 1987. In February 1988, the insurer denied claimant's claim.

In April 1987, claimant and her son, as co-owners of a marina, instituted a lawsuit against the former owners of the marina. On December 20, 1987, claimant's father died after a lengthy illness. In January 1988, Bielke voluntarily resigned from his supervisor post and returned to sales work for the employer.

FINDINGS OF ULTIMATE FACT

Claimant's difficulties with her supervisors were real events.

Claimant's work activities were the major contributing cause of her stress condition and need for treatment.

CONCLUSIONS OF LAW

The Referee concluded that claimant had not established that her work activities were the major contributing cause of her stress condition. We disagree.

Stress claims arising out of mental and physical disorders are compensable if they result from real conditions of the worker's employment and those conditions, when compared to non-work conditions, are the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145, 166 (1983). Claimant's subjective reaction to work events need not have been reasonable or rational. See Leary v. Pacific Northwest Bell, 67 Or App 766 (1984). The medical effect on her is measured by her actual reaction, rather than by an objective standard of whether the conditions would have caused disability in an average worker. Peterson v. SAIF, 78 Or App 167, 170 (1986). The stressful conditions must be objective, however, in that they must be real.

Dr. Worthington, claimant's treating psychologist, diagnosed an adjustment disorder and opined that claimant's work activities were the major cause of her stress condition. He noted that claimant's interpersonal relationships at work, in particular the ongoing dispute with her supervisor over practices she thought to be unethical and incompetent, had caused an acute psychological disturbance. Dr. Worthington also testified that he was aware of claimant's pending lawsuit, as well as the death of her father, but maintained that her work activities were the major cause of her stress condition.

Dr. Turco, psychiatrist, also diagnosed an adjustment disorder, but opined that claimant's work activities were not the major cause of the condition. He felt that claimant had multiple off-work stressors, such as her father's death, and her impending lawsuit, and found it difficult to believe that her employer would treat her badly for a malicious purpose.

Absent persuasive reasons to the contrary, we generally accord greater weight to the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). In this case, Dr. Worthington has treated claimant since the onset of her stress-related disability. In addition, he was aware of the off-work stressors. We are persuaded by Dr. Worthington's well-reasoned opinion. We are not persuaded by Dr. Turco's contrary opinion. Dr. Turco's understanding of the incidents at claimant's work place is not consistent with claimant's testimony of those events.

Accordingly, we conclude that claimant has established that her work activities were the major contributing cause of her stress condition.

ORDER

The Referee's order dated, July 5, 1988, is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services rendered at hearing, claimant's hearings counsel is awarded a reasonable assessed fee of $1,300. For services rendered on review, claimant's review counsel is awarded a reasonable assessed fee of $750.

EUSTOLIO C. RODRIGUEZ, Claimant
Bottini, et al., Claimant's Attorneys
Lester Huntsinger (SAIF), Defense Attorney

WCB 87-10556
December 20, 1989
Order on Review

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of that portion of Referee Livesley's order that affirmed the Evaluation Division's termination of her permanent total disability award. In lieu of submitting a Respondent's Brief, the SAIF Corporation relies on the Referee's order.

The Board reverses the order of the Referee and reinstates claimant's award of permanent total disability.

ISSUE

Whether SAIF met its burden of proving a change in circumstances sufficient to warrant a finding that, at the time of hearing, claimant was no longer permanently incapacitated from regularly performing work at a gainful and suitable occupation, so that she was no longer entitled to an award of permanent total disability.

FINDINGS OF FACT

Claimant, 42 at the hearing, sustained a compensable injury to her low back on November 14, 1980. Diagnostic studies revealed a disc herniation at L4-5. On November 28, 1980, she underwent low back surgery. A Determination Order closed her claim in August 1981, with an award of 15 percent unscheduled permanent disability. She requested a hearing. In August 1982, a prior referee awarded her permanent total disability.

Before her November 1980 injury, claimant had been hospitalized on at least five occasions with pain complaints associated with diagnosed hysterical personality features. In the four years following the August 1982 award, claimant presented to a hospital emergency room on approximately 13 occasions with complaints of back pain. In June 1986, SAIF sent her to the Northwest Pain Center. She made progress in learning to deal with her pain in that program. No occupational opportunities were identified by the vocational experts on the pain center staff.

Vocational Rehabilitation services were commenced in October 1986. At that time, claimant's physician, Dr. Waldmann, M.D., had not released her to work.

In January 1987, claimant's vocational file was transferred to a Spanish speaking counselor, Steve Rau. Rau began to focus vocational efforts on obtaining Dr. Waldmann's approval of two light duty sewing jobs: (1) lamp shade sewer; and (2) sewing machine operator. Rau expected the latter job to allow claimant to "work in her own home and at her own pace." In April 1987, Waldmann released claimant to both jobs with that understanding.

While able to perform sedentary work on a regular basis from the standpoint of her ability to lift and to carry, claimant is unable to do so in terms of her ability to sit and stand.

Claimant can sit or stand for a total of only two hours per day. She can sit or stand for a maximum of one hour at a stretch.

Claimant's education is limited to two years of schooling in rural Mexico. She can not speak, read, or write in English. Although she can perform simple arithmetic problems, she can not multiply or divide. Her work history consists of working in fruit and produce fields since the age of 11. At the time of her compensable back injury, she had been working as a cannery laborer for approximately two years. She has received no vocational training.

Claimant has no transferable skills for gainful and suitable work. She sews from time to time at home. She does not own a sewing machine but has used a machine to sew "in my own way." She has not sewed as a means of employment.

Although at-home work is available for seamstresses beginning at a minimum wage, there is no persuasive evidence to establish that an individual with claimant's physical limitations could produce enough work on an hourly basis to gain and hold such a position. Nor is there persuasive evidence that such a position would produce regular income for claimant.

In June 1987, pursuant to SAIF's request, a Determination Order issued, stating, inter alia:

> "THE DEPARTMENT, UPON REQUEST FOR A REDETERMINATION FINDS THAT YOU ARE NO LONGER PERMANENTLY AND TOTALLY DISABLED. THE DEPARTMENT ORDERS YOUR PERMANENT TOTAL DISABILITY BENEFITS STOPPED AS OF JUNE 15, 1987."

FINDINGS OF ULTIMATE FACT

Neither claimant's physical condition nor the circumstances bearing on her employability have changed since claimant was first awarded permanent total disability.

Claimant is permanently incapacitated from regular employment at a gainful and suitable occupation.

CONCLUSIONS OF LAW

To terminate claimant's award of permanent total disability, SAIF "has the burden of proving 'a change of circumstances sufficient to warrant the relief sought.'" Harris v. SAIF, 292 Or 683, 690 (1982); see ORS 656.206(5). A "change of circumstances" can be shown by proof of improvement in a worker's medical condition or by circumstantial evidence of employability. Kytola v. Boise Cascade Corp., 78 Or App 108, 111 (1986). The evidence must demonstrate that claimant is employable in a recognized segment of the labor market. Harris, supra.

Here, the Referee affirmed that portion of the Determination Order that terminated claimant's award of permanent total disability. We do not agree.

Emotional Overlay

First, the Referee incorrectly focused much of his attention on claimant's emotional adjustment to her compensable injury. Claimant's hysterical personality features are well documented in

the record. However, her current emotional overlay is no different than the features she demonstrated prior to the compensable injury and at the time of her August 1982 award of permanent and total disability. Consequently, evidence that claimant has hysterical personality features provides little assistance to us in determining whether a change of circumstances has occurred warranting termination of that award. Moreover, insofar as they are disabling, these features existed prior to claimant's compensable injury and thus must be taken into account in determining whether or not she continues to be permanently and totally disabled. ORS 656.206(1)(a) and 656.206(5).

Pain Complaints at Hearing

Second, the Referee found that claimant did not "appear" to be in any distress during the six-hour hearing. In fact, however, claimant's testimony indicates that she "appeared" to be in some distress:

> "Q. [Claimant's Attorney] Are your [sic] problems now after sitting here for -- since we began the hearing?
>
> "A. [Claimant] Yes.
>
> "Q. [Claimant's Attorney] Can you sit for longer that one or two hours but with pain?
>
> "A. [Claimant] No, I can not stay sitting this way, not with pain.
>
> "Q. [Claimant's Attorney] And is that why you stand?
>
> "A. [Claimant] Yes."

Medical and Vocational Evidence

Third, the Referee stated that Dr. Waldmann was of the opinion that claimant was "not totally disabled." While technically correct, the complete text of Waldmann's opinion places it in the proper context:

> "It is my opinion that [claimant] is moderately disabled[,] but not totally disabled.
>
> "Subsequent to this, I believe that she would be capable of employment if it was of a 'light duty' nature performed at home and up to 8 hours per day[,] but less hours if preferred by the [claimant]."

As can be seen, Waldmann qualified his statement of "not totally disabled" by indicating the type of employment he felt claimant was capable of performing. Moreover, the Job Analysis of the at-home sewing job Dr. Waldmann approved provides the following description:

> "May be modified to provide ergonomic chair. This is light duty work - the worker may be able to operate in her own home - lifting is

minimal and there is flexibility for the worker to sit or stand, or take a break as need - salary is based on production."

In our view, Dr. Waldmann was of the opinion that claimant's physical capacities were quite limited. In October 1986, Waldmann restricted claimant to: (1) no sitting or standing beyond one hour in an 8 hour work day; (2) no walking beyond two hours in an 8 hour work day; (3) no lifting or carrying beyond 6 pounds; (4) no repetitive movements of her left or right foot; and (5) no bending, squatting, crawling, or climbing. At that time, Waldmann diagnosed: "Chronic back pain and hysterical personality." He also declined to release claimant to work.

Dr. Waldmann's subsequent release to work pertained to the above described at-home sewing job and a similarly described job as a lamp shade sewer. Given the narrow scope of Waldmann's release to work and the extent of the physical restrictions he placed on claimant, we do not view his opinion as supporting a finding that claimant's medical condition has improved or that she is presently employable.

Permanent total disability "permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a) & (5). The essence of permanent total disability is "the probable dependability with which claimant can sell h[er] services in a competitive labor market...." Harris, supra, 292 Or at 695, quoting from 2 Larson Workman's Compensation Law, sec. 57.51, at 10-164.49 (1981).

Here, claimant is 42 years of age. Her education is limited to two years of schooling in rural Mexico. She can not speak, read, or write in English. Although she can perform simple arithmetic problems, she can not multiply or divide. Her work history consists of working in fruit and produce fields since the age of 11. At the time of her compensable back injury, she had been working as a cannery laborer for approximately two years. She has received no vocational training.

Despite vocational assistance, no realistic transferable skills were identified by counselor Machorro. In October 1986, Machorro initially indicated that claimant had "considerable transferable skills" in the area of "field/agricultural work." Yet, "field/agricultural work" is precisely the type of heavy manual work that claimant is no longer capable of performing due to her permanent back disability. After receiving the Physical Capacities Evaluation form from Dr. Waldmann, Machorro opined, inter alia: "[W]ith some limitations the [claimant] could return to work to a sedentary level occupation...." However, Machorro neither identified a specific sedentary job that claimant was capable of performing nor recommended any training so that claimant could learn to perform such a job.

Similarly, the only transferable skill identified by counselor Rau was sewing. Nothing in the record, however, indicates that claimant had skills in that area beyond the routine performance of occasional at-home sewing chores. Furthermore, the two work releases obtained from Dr. Waldmann (i.e., Sewing Machine Operator and Lamp Shade Sewer) allowed claimant to work either at home or less than eight hours a day. On March 26, 1987, counselor Rau reported, inter alia: "Meet with treating physician on 4/7/87 to discuss worker's ability to participate in modified employment as a seamstress." (Emphasis added). In our view, claimant's

ability to perform the above two sewing positions does not indicate that she has the ability to sell her services in a competitive labor market. Moreover, we find that the above two sewing positions are not "gainful and suitable occupations" within the meaning of ORS 656.206(5). See Harris, supra, 292 Or at 695.

Supporting our view is the opinion of vocational expert Milholm, who stated, inter alia:

> "It is clear to me without reservation that [claimant] is classified as permanent and total disability. No vocational counselor has come up with a viable work alternative that is even closely appropriate to her physical capabilities, aptitude and language barriers. Of the numerous permanent and total disability workers I have come across, this woman appears to be one of the most obvious cases I have seen in a very long time."

Surveillance Tape

The Referee stated that the surveillance tape showed claimant performing various physical activities "with no apparent distress." The tape was taken over a two-day period and totaled 46 minutes in length. 43 1/2 minutes of the tape were taken between 12:43 and 4:45 on June 5, 1987. The tape reveals claimant properly bending, carrying a half load of laundry, and slowly walking.

We are not persuaded, however, that such sporadic activities taken over a 4-1/2 hour period prove that claimant's medical condition has changed or that she is presently employable. Kytola, supra, 78 Or App at 111. In fact, claimant testified that she spends her free time feeding her chickens, cooking food for her family, and occasionally hanging laundry. The surveillance tape does little to rebut her testimony. Moreover, the tape does not reveal claimant's condition before and after the taped activities. Claimant testified that during the afternoon of June 5, 1987, she went into her house on several occasions to lie down because the exertion was physically taxing.

"Seek Work" Requirement

Last, the Referee incorrectly applied the statutory "seek work" requirement, ORS 656.206(3), to this case. That statute provides:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment." (Emphasis added).

The correct statute to apply here, however, is ORS 656.206(5). Unlike ORS 656.206(3), ORS 656.206(5) places the burden upon the insurer to show "a change in circumstances" indicating that claimant is currently employable. Id. In a termination proceeding, a claimant's motivation and efforts are not directly in issue.

Accordingly, on this record, having found that claimant remains incapacitated from regular employment, we conclude that SAIF has not met its burden of proving "a change in circumstances" sufficient to warrant the termination of claimant's award of permanent total disability.

ORDER

The Referee's order, dated January 15, 1988, is reversed. Claimant's award of permanent total disability is reinstated. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation awarded by this order, not to exceed $6,000.

CLARENCE C. CLEMENTS, Claimant
Harper, Leo & Associates, Claimant's Attys.
Randolph Harris (SAIF), Defense Attorney

WCB 88-01851
December 21, 1989
Order on Review

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Bennett's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for an epileptic seizure; and (2) declined to assess penalties and attorney fees for alleged unreasonable claims processing. On review, the issues are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Board adopts that portion of the Referee's opinion addressing compensability with the following comments.

We do not rely on or agree with the second full paragraph of page 4 of the Referee's order. We rely, instead, on the fact that Dr. Anderson's opinion supporting causation was considerably weakened by his change of opinion when given additional information. Since he is the only doctor to find causation, and since his latest opinion is totally contrary to his first, his opinion supporting causation cannot be relied on. This is so even if the information leading to the second report is not accurate. Neither report is based on totally accurate facts.

We turn to the penalty and attorney fee issue. SAIF received claimant's injury claim on October 23, 1987. It issued its denial on January 4, 1988. The Referee found that SAIF had failed to accept or deny the claim within 60 days. However, reasoning that claimant did not show prejudice, the Referee concluded that penalties and attorney fees were not assessable. Although we agree with the Referee's ultimate conclusion, we use different reasoning.

An insurer must accept or deny a claim within 60 days or risk the imposition of penalties, based on "amounts then due," and attorney fees. ORS 656.262(6) and (10). Claimant correctly argues that he would be entitled to interim compensation whether his claim was compensable or not. However, we are not persuaded that he lost any time from work. The seizure occurred during his rest day; his time report indicates he worked 12 hours the day

after his seizure; and his attorney stated at hearing that claimant had suffered no time loss. Because no interim compensation was due, there is no amount upon which to calculate a penalty.

Unlike a penalty, an award of attorney fees is assessed under ORS 656.382, for unreasonably resisting the payment of compensation. Because there was no unreasonable resistance to the payment of compensation, no attorney fees are due. Ellis v. McCall Insulation, 308 Or 74, 78 (1989); Lloyd C. Cripe, 41 Van Natta 1774 (October 23, 1989).

Finally, claimant contends that SAIF's denial was unreasonable. SAIF based its January 4, 1988 denial on the two medical reports in the file at that time. Neither report attributed claimant's seizure to his work activities. We conclude that SAIF had a legitimate doubt concerning whether a causative relationship had been established between the seizure and claimant's work. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Therefore, SAIF's denial was not unreasonable.

ORDER

The Referee's order dated May 16, 1988 is affirmed.

THOMAS S. CORSEY, Claimant	WCB 86-15226
Emmons, Kyle, et al., Claimant's Attorneys	December 21, 1989
Cowling & Heysell, Defense Attorneys	Order on Review

Reviewed by Board Members Crider and Brittingham.

The self-insured employer requests review of that portion of Referee Seymour's order that granted claimant an award of permanent total disability, whereas a Determination Order awarded 60 percent (192 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability, including permanent and total disability.

The Board affirms the order of the Referee.

FINDINGS OF FACT AND ULTIMATE FACT

The Board adopts the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's opinion with the following supplementation.

Permanent total disability need not derive solely from a worker's medical or physical incapacity. Emerson v. ITT Continental Baking Co., 45 Or App 1089 (1980). Under the "odd-lot" doctrine, a worker may prove permanent total disability based on his physical impairment, age, education, adaptability to nonphysical labor, and emotional conditions. Clark v. Boise Cascade Co., 72 Or App 397 (1985). In addition, a worker is required to make reasonable efforts to obtain regular gainful employment, unless it would be futile to do so. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Here, the Referee did not specify whether he found claimant permanently totally disabled based solely on his physical condition or under the "odd-lot" doctrine. After our de novo review, we find that claimant has established permanent total disability based on either theory.

Physical Condition

Dr. Endicott, claimant's family physician, see Weiland v. SAIF, 64 Or App 810, 814 (1983), opined that claimant was "totally disabled because of his back pain, leg pain and muscle spasm of the back." Buttressing Endicott's opinion is Dr. Tsai, a neurosurgeon, who performed claimant's initial disc surgery in August 1979, who testified, inter alia:

> "Q. I presume, Doctor [Tsai], when you rendered reports on unemployability you confined yourself to the physical factors, or have you included vocational factors in your assessment?
>
> "A. I, in my experience, a patient who has been suffering from chronic pain over such a long time, I think, probability to return to work, rehabilitation, is very small percentage."

The employer argues, however, that when Dr. Endicott was asked to exclude consideration of claimant's "subjective complaints," he no longer viewed him as totally disabled. (Ex. 99-26). We are not persuaded by the employer's argument.

In our view, Dr. Endicott properly considered claimant's subjective complaints in assessing his physical capacities. Endicott has treated claimant for several years. Not once, on this record, did he indicate that claimant's subjective complaints were out-of-line with objective findings. In fact, to the contrary, Endicott testified that claimant's symptoms were consistent with objective findings. (Ex. 99.29, 99.30). Moreover, a worker's complaints of disabling pain are properly considered by the trier of fact in determining the extent of a worker's permanent disability. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

Accordingly, we find that claimant is permanently and totally disabled based solely on his physical condition.

"Odd-Lot" Doctrine

As we found above, claimant has significant physical impairment. At the time of the hearing, he was 42 years of age. He graduated from high school in 1963 and received no further formal education. His IQ has been rated at 75 to 76. His job history primarily consists of heavy labor occupations, including farming, forklift driving, and dryer feeding. He has few identified transferable skills to lighter occupations.

Under such circumstances, we conclude that claimant is permanently and totally disabled under the "odd-lot" doctrine.

Furthermore, given claimant's significant physical impairment, his lack of education, his low IQ, and his lack of

transferable skills, we conclude that it would be futile for him to seek regular gainful employment. Butcher v. SAIF, supra.

Claimant's attorney is entitled to an assessed fee, OAR 438-15-005(2), for his services on Board review. OAR 438-15-070. However, because, as of this date, we have not received a statement of services from claimant's attorney, we can not award an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order, dated January 21, 1988, is affirmed. The Board approves a client-paid fee, payable from the self-insured employer to its attorney, not to exceed $352.

MARY B. DOUGLAS, Claimant
Merrill & O'Sullivan, Claimant's Attorneys
Gray, et al., Attorneys
Lester Huntsinger (SAIF), Defense Attorney

WCB 87-07198 & 87-05296
December 21, 1989
Order on Review

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Livesley's order that upheld the SAIF Corporation's denial of claimant's back injury claim on behalf of the noncomplying employer. On review, the issue is compensability.

We affirm and adopt the Referee's order, with the following additional conclusions of law and opinion.

The Referee concluded claimant had not established that her injury arose out of and in the course of her employment. We agree. Claimant contends she suffered a back injury on May 7, 1986, when she and her employers, Paul and Lynn Jackson, attempted to push a large and heavy cooler approximately four feet into a corner of a supply room. Claimant testified that the cooler had previously been moved out of the corner by Mr. Jackson for the purpose of repair, and to enable claimant to use a compressor to blow the dust out of the fan area located on the bottom of the cooler.

Claimant's version of events sharply conflicts with the testimony given by her employers. Therefore, the compensability of claimant's claim ultimately rests upon her credibility and reliability as a historian. The Referee made no specific credibility finding.

When credibility of a witness is based upon the evidence in the record and the substance of the witness' testimony, a reviewing body is capable of evaluating the witness. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). We, therefore, proceed to evaluate for ourselves the substance of the witness' testimony.

At hearing both employers testified. Their testimony, in particular that of Mr. Jackson, refutes claimant's version of events in almost every particular. In comparing claimant's testimony and her employer's testimony, we find Mr. Jackson's testimony with respect to the alleged events of May 7, 1986, to be more persuasive. Mr. Jackson made three salient points. He stated that in order to clean the dust out of the compressor area, removal of the front grill was all that was required. Contrary to claimant's assertion, there was no reason to move the cooler as

there was no need to gain access to the rear of the cooler. Second, claimant indicated Mr. Jackson had moved the cooler without aid of equipment. However, Mr. Jackson indicated that it was physically impossible for him to move the 1,000 pound cooler out of the corner unassisted even if he had chosen to do so. Finally, Mr. Jackson testified that the compressor used for filling car tires was kept out in front of the store, and was never used for cleaning out the fan area as suggested by claimant. Mr. Jackson explained that the cleaning function, which was done on occasion, was always accomplished by use of a vacuum cleaner.

Based on Mr. Jackson's persuasive testimony, we find it more probable than not that the act of pushing the cooler back into place as described by claimant did not take place. Furthermore, claimant's version of events, although possible, is not believable. See generally Frazier v. United Pacific Insurance, 91 Or App 528, 531 (1988).

Additionally, there are other factors to consider. As a result of the alleged injury, claimant did not lessen her activities in any respect. Immediately following the alleged injury, she worked the rest of the day. That evening, she drove with a friend to San Francisco. Upon her return, she missed no time from work, nor was she unable to continue with her house cleaning business. Claimant did not seek medical care until July 18, 1986, some three months after the alleged injury.

Finally, there are several other events which may be responsible for claimant's condition. Claimant had sustained injuries when she was a child and thrown from a horse. In 1970 she suffered a "whiplash" injury. In 1978 she fell with a horse on ice. In 1985 a horse knocked her down while shoeing. In addition, between the date of the alleged injury and the date she sought medical treatment on July 18, 1986, claimant had engaged in several vigorous equestrian competitions.

In conclusion, the totality of the evidence indicates that an injury in the manner described by claimant was unlikely to have occurred. Consequently, we do not consider claimant's testimony to be persuasive. Given this finding, we decline to rely on medical evidence which is based on claimant's history. Therefore, the medical opinions of chiropractors Hiskey and Ries, which support a causal connection between claimant's condition and employment, are likewise not persuasive. Accordingly, we conclude that claimant has not sustained her burden of proof that the alleged industrial injury was a material contributing cause of her back condition.

ORDER

The Referee's order, dated December 1, 1987, is affirmed.

HERMAN L. GREENE, JR., Claimant
Merrill Schneider, Claimant's Attorney
Alice M. Bartelt, Defense Attorney

WCB 87-02883
December 21, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

The insurer requests review of those portions of Referee Galton's order that: (1) assessed a penalty for an allegedly unreasonable failure to close claimant's low back injury claim; and (2) based that penalty, in part, on medical billings. On review, the insurer contends that the Referee improperly assessed penalties based on medical bills, and that its conduct in failing to process the claim to closure was not unreasonable. We modify in part.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and ultimate fact, as supplemented.

There were no unpaid billings for medical services at the time of the insurer's unreasonable failure to close claimant's low back claim, nor at the time of hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee found the insurer's conduct unreasonable in its refusal to: (1) process the claim and pay temporary partial disability; (2) secure the documentation necessary to close the claim; and (3) enter a Notice of Closure or submit the claim for closure to the Evaluation Division. For this unreasonable conduct, the Referee assessed a 25 percent penalty based on: (1) unpaid temporary partial disability; (2) any permanent disability award allowed by a future Determination Order; and (3) medical services incurred from March 2, 1987 through the date of the Referee's order. We agree with the Referee's assessment of a penalty for unreasonable refusal to process, but disagree that medical services should be included as a basis for that penalty.

Former ORS 656.268(2) provides:

> "When the injured worker's condition resulting from a disabling injury has become medically stationary . . . the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim
> be examined and further compensation, if any, be determined."

This duty to timely close a claim includes obtaining additional medical information preliminary and necessary to claim closure. Penalties and attorney fees will be assessed for unreasonable delay in performing that duty. Lester v. Weyerhaeuser, 70 Or App 307, 310 (1984); Georgia Pacific v. Awmiller, 64 Or App 56 (1983). If the claim is still open at the time that the issue of unreasonable delay in claim closure is litigated, a penalty may be assessed on any permanent disability or unpaid temporary disability compensation ultimately awarded at the time of claim closure. See Chester R. Rhodes, 38 Van Natta 1396, 1398 (1986).

Here, a prior Referee's order dated October 20, 1986, set aside that part of the insurer's denial that denied claimant's low back condition and need for care and treatment. On October 27, 1986, the insurer issued a 1502 form, "Insurer's Report," indicating that the claim was accepted and classified as disabling. During that period of time, claimant was not released for regular work.

On February 26, 1987, the employer's plant physician, Dr. Semler, in a pre-employment physical examined claimant and indicated that he could return to work. Despite the fact claimant did not have a release from Dr. Bolera, his treating chiropractor, he returned to regular work on March 2, 1987. The insurer, however, made no attempt to determine whether or not claimant was stationary. On inquiry by claimant's attorney, the insurer's attorney indicated that the claim would not be closed. Thus, the insurer failed to properly process the claim. The insurer's apparent explanation for its inaction was that it considered the claim nondisabling, and hence, neither closure nor a Determination Order was required. We do not find this explanation reasonable, as the insurer had expressly classified the claim as disabling. Moreover, Notice of Closure is required for nondisabling claims for injuries occurring in 1984. Former ORS 656.268(3).

Such unreasonable conduct will support a penalty and related attorney fee. Yet, we disagree with the Referee's assessment of a penalty for a failure to close the claim based on medical services for the period from March 2, 1987, through the date of the Referee's order. In order for a penalty to be assessed, there must have been an amount of compensation due and unpaid. See EBI Companies v. Thomas, 66 Or App 105, 111 (1983). Here, although the insurer classified claimant's injury as disabling, it then proceeded to treat the claim as if it was nondisabling. Despite this contradictory action, medical services were promptly paid. Thus, unlike claimant's temporary disability benefits and potential future award of permanent disability, medical services were not "withheld." Under such circumstances, it would be inappropriate to assess a penalty based on medical services. Accordingly, the penalty insofar as it pertains to the insurer's failure to timely close the claim will be based solely on unpaid temporary disability benefits and permanent disability awarded on claim closure. Chester R. Rhodes, supra.

Finally, inasmuch as "penalties" are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to attorney fees for successfully defending those awards on Board review. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated November 17, 1987 is modified in part. In lieu of the Referee's assessment of a penalty for the insurer's unreasonable failure to close claimant's low back injury claim, the insurer shall pay claimant an additional 25 percent of any unpaid temporary disability benefits and permanent disability awarded at closure. The remainder of the Referee's order is affirmed.

STEVEN C. LAXTON, Claimant
Pozzi, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 87-08526
December 21, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

The self-insured employer requests review of Referee Heitkemper's order which set aside its denial of claimant's occupational disease claim for his psychological condition. In addition, claimant has moved for dismissal of the employer's request for review on the basis of alleged misconduct. On review, the issues are dismissal and compensability. We deny the motion to dismiss and reverse on the compensability issue.

Claimant submitted a motion to dismiss the employer's request for Board review because of ex parte contact with the Board on the part of the employer's claims manager. Claimant's allegations result from an August 8, 1989 letter from the claims manager to the Board.

We have considered the claims examiner's letter only as a request to expedite Board review. Any other statements in the letter are not a part of the record and cannot be considered in deciding the case. Accordingly, claimant's motion to dismiss the request for Board review is denied. See, Edward O. Miller, 36 Van Natta 1578 (1984).

FINDINGS OF FACT

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

Some incidents, as perceived and related by claimant, were not real events.

CONCLUSIONS OF LAW AND OPINION

Stress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from stressful conditions objectively existing on the job, and those work conditions, when compared to non-employment conditions, are the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145, 166 (1983). Claimant's reaction to the work events need not have been reasonable or rational. If claimant reacted to real events which were objectively stressful, he has a basis for a stress claim. See, Leary v. Pacific Northwest Bell, 67 Or App 766 (1984).

The Referee concluded that real events and conditions of employment actually occurred and were objectively stressful, and that these events and conditions were the major contributing cause of claimant's condition. In rendering his conclusions, he relied on the opinion of Dr. Dewey.

The employer contends that claimant's condition is not compensable, because his stress arose from either fictional events or claimant's misperceptions of events, rather than real events or conditions of work. In particular, the employer argues that claimant's perception of facts concerning the pickup truck incident in the parking lot and the circumstances of the 7-11 incident, with the numerous rewritings of the report, were in large part fictional events. We agree.

The parking lot incident is particularly important as it was the "precipitating" event leading to claimant's condition. In his testimony, claimant was very certain about the speed of the oncoming pickup truck (40 to 50 mph) and the distance (30 feet) it was away from claimant. However, Mr. Wong, an expert in mechanical engineering and accident reconstruction, stated that, given the speed claimant testified the truck was traveling, the truck would have traveled between 59 and 73 feet in one second. We are persuaded by Mr. Wong's expert testimony on this point. Thus, if claimant's perception of the parking lot incident was accurate, he would have been unable to avoid being struck by the truck. Other aspects of claimant's perceptions of the parking lot incident were equally improbable. We, therefore, conclude that the parking lot incident, as perceived and related by claimant, was not a real event.

Similarly, claimant's version of the 7-11 incident contains both inconsistencies and facts that are not feasible. Claimant, in relating the incident to one doctor, stated that he was approached by persons who told him two men appeared to be robbing the 7-11 store. He told another doctor that he had observed the two men himself and suspected a robbery attempt. Additionally, concerning claimant's written report of the incident, he stated that he had to write and rewrite the one-page report serveral times, each time reliving the stressful incident. Each rewrite allegedly required 4 to 6 hours of claimant's time.

The inconsistencies and improbability in claimant's descriptions of the 7-11 incident create further doubt as to whether other events as related by claimant are real, or instead are claimant's misperceptions of reality.

Because we find that claimant misperceives reality, we conclude that the bases upon which the medical opinions were founded were not real, but, rather, were based on claimant's erroneous impressions. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinions based on inaccruate histories are not persuasive).

The Referee relies on Dr. Dewey, as claimant's treating psychologist. However, the record shows that Dr. Bernstein had conducted psychological evaluations on claimant in 1984 and again in 1987 before Dr. Dewey first met with claimant.

In addition, we do not rely on Dr. Dewey's opinion because that opinion is dependent upon claimant's reporting to Dr. Dewey. We have previously found that claimant's reports of events are not reliable in that he misperceives those events. See Miller, supra. Moreover, Dr. Dewey tends more toward diagnosing claimant's supervisors than claimant himself. Accordingly, we do not find Dr. Dewey's opinion to be persuasive in supporting claimant's contention that employment conditions were the major contributing cause of his mental stress condition.

For the above-mentioned reasons, we conclude that claimant has not established that the alleged work-related events which caused his condition were real. Accordingly, claimant has failed to sustain his burden of proof. See Leary v. Pacific Northwest Bell, 67 Or App 766 (1984) (mental stress claim found not compensable where some of the stress-causing conditions were real and others were imagined).

ORDER

The Referee's order dated April 20, 1988 is reversed. The self-insured employer's May 20, 1987 denial is reinstated and upheld. A client-paid fee, not to exceed $2,575, is approved.

DONALD J. MARA, Claimant
Coons & Cole, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-18019
December 21, 1989
Order on Review

Reviewed by Board Members Crider and Nichols.

The insurer requests review of those portions of Referee Livesley's order that: (1) set aside its "de facto" denial of claimant's out-of-state medical services claim; and (2) assessed an attorney fee for its allegedly unreasonable claims processing. Although claimant has not formally cross-requested review, he argues in his brief on review that the Referee erred in not assessing a penalty in addition to the aforementioned attorney fee. On review, the issues are medical services and penalties and attorney fees.

We affirm and adopt that portion of the Referee's order which found claimant's medical services claim compensable. We reverse that portion of the order which declined to assess a penalty for failing to accept or deny the claim in a timely manner. Finally, we affirm the Referee's assessment of a penalty-associated attorney fee, with supplementation.

The Referee declined to assess a penalty because "the [medical] bills are not in evidence." While that may be true, the nonpayment of claimant's bills was conceded by the insurer. (Ex. 5; Tr. 4). Inasmuch as the insurer failed to either accept or deny the claim in a timely manner, a penalty for its unreasonable conduct is justified. See ORS 656.262(6); 656.262(10). Consequently, we assess a penalty equal to 25 percent of the amounts "then due," i.e., claimant's unpaid out-of-state medical services claims.

Finally, we agree with the Referee's assessment of a penalty-associated attorney fee. Here, the insurer's failure to timely respond to claimant's medical services claim constitutes an unreasonable resistance to the payment of compensation. Accordingly, an attorney fee is warranted. ORS 656.262(10); 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (October 23, 1989).

ORDER

The Referee's order, dated March 25, 1988, is affirmed in part and reversed in part. The insurer is directed to pay a penalty equal to 25 percent of claimant's unpaid out-of-state medical services claims. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,309.50.

KENNY W. MEUSER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Employers Defense Counsel, Defense Attorney

WCB 88-03952
December 21, 1989
Order on Review

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Mongrain's order which set aside its partial denial of claimant's cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In June 1985, claimant sustained a compensable right shoulder injury. It was accepted by the insurer as a nondisabling right shoulder strain. Claimant continued to work at his regular plywood mill job until February 1986. Thereafter, he successively worked for two other plywood mills over the course of one year. In February 1987, he left his last employment due to increased right shoulder pain.

In May 1987, he sought treatment for right cervical, shoulder and arm pain. On July 6, 1987, Dr. Womack reported that claimant was temporarily disabled from his regular work. The insurer reopened claimant's claim and paid time loss benefits. The claim was closed by a October 2, 1987 Notice of Closure.

In December 1987, claimant was seen by Dr. Smith. He reviewed x-rays and recommended that claimant undergo a discogram at C5-6 and C6-7. The discogram and subsequent myelogram were interpreted as showing a probable herniated disc at C5-6, as well as degenerative changes at C6-7.

In January 1988, a Determination Order affirmed the October 1987 Notice of Closure in all respects. In March 1988, the insurer denied claimant's aggravation claim and current medical benefits on the basis that his current cervical condition was not related to the 1985 compensable injury.

FINDINGS OF ULTIMATE FACT

Claimant's cervical condition is not materially related to his 1985 compensable injury.

CONCLUSIONS OF LAW

The Referee concluded that claimant's cervical condition was materially related to the 1985 compensable injury and set aside the insurer's denial. We disagree.

At the outset, we note that the insurer's denial is framed as a denial of both an aggravation and current medical services. Therefore, to prove either an aggravation or entitlement to current medical services, claimant must establish a material causal connection between the 1985 compensable injury and his current allegedly worsened condition. He has not done so.

The issue of whether claimant's industrial injury is materially related to his current cervical condition 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).

In June 1987, Dr. Womack characterized claimant's conditions as a "re-exacerbation" of his compensable 1985 injury. He further noted that claimant may have future re-exacerbations referable from the cervical nerve roots. Importantly, however, Dr. Womack rendered his opinion before claimant's allegedly worsened condition of December, 1987. Moreover, Dr. Womack offered no explanation for his conclusion that claimant's cervical pain was related to the 1985 injury. Finally, it is not clear whether Dr. Womack was diagnosing a new cervical condition or relating all of claimant's symptoms to the 1985 right shoulder strain. In sum, we assign little weight to Womack's opinion because it was rendered before the alleged worsening at issue. In addition, he lacks a persuasive medical analysis to support his conclusions. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Dr. Kuller opined that it was medically unlikely that claimant's cervical condition was related to the 1985 compensable injury. He also noted that claimant had minimal objective findings at his three examinations. Western Medical Consultants could not say whether claimant's current condition was causally related to his 1985 compensable injury. Drs. Schefstrom and Conwell concurred with the Consultants' opinion. Dr. Smith did not offer an opinion as to a causal relationship between the cervical condition and the 1985 compensable injury. We are persuaded by Dr. Kuller's well-reasoned opinion.

Under these circumstances, we conclude that claimant has failed to establish that either his current cervical condition or his allegedly worsened condition is causally related to the 1985 compensable injury.

ORDER

The Referee's order, dated July 20, 1988, is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, not to exceed $1,524, is approved.

MARY F. MILO, Claimant	WCB 88-04545
Leistner, et al., Claimant's Attorneys	December 21, 1989
Daryll E. Klein, Defense Attorney	Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Livesley's order that set aside its denial of claimant's chiropractic, acupuncture, and diagnostic medical services for her current low back condition. On review, the issue is medical services.

We review de novo and, for reasons different from those stated in the Referee's order, affirm the Referee.

FINDINGS OF FACT

We adopt the Referee's findings and make the following additional finding. The insurer's medical services denial, dated February 11, 1988, denied all further treatment resulting from the May, 1985, compensable injury.

CONCLUSIONS OF LAW

Concluding that claimant had proven the merits of her case, the Referee set aside the insurer's medical services denial. Although we agree that the insurer's denial must be set aside, we do so without reaching the merits.

It is well settled that an insurer may not prospectively deny medical services beyond the date of its denial. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, the insurer's denial concludes: "We are therefore denying responsibility for any further treatment for the above referenced [May, 1985,] accident." (Emphasis added). In our view, a denial of "any further treatment" is an impermissible prospective denial. It inescapably denies all future treatment in violation of claimant's right under ORS 656.245(1) to prove entitlement to medical services due to the compensable injury for the duration of her life.

Accordingly, pursuant to Striplin, supra, we conclude that the insurer's medical services denial must be set aside as an impermissible prospective denial.

ORDER

The Referee's order, dated April 27, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by the insurer. A client-paid fee not to exceed $376, payable from the insurer to its counsel, is approved.

THEODORE L. NOMELAND, Claimant — WCB 88-01084
Charles Robinowitz, Claimant's Attorney — December 21, 1989
David Jorling, Defense Attorney — Order of Abatement

The Board has received claimant's motion for reconsideration of our Order on Review dated December 8, 1989.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The self-insured employer is requested to file a response to the motion within ten days from the date of this order. Thereafter, the matter will be taken under advisement.

IT IS SO ORDERED.

SIDNEY H. PRIEST, Claimant — WCB 87-12900
Pozzi, Wilson, et al., Claimant's Attorneys — December 21, 1989
Roberts, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of Referee Wasley's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact contained in the first page and the first four complete paragraphs of the second page of his order with the following supplementation.

During February, 1987 claimant received a total of seven

chiropractic treatments from Dr. Peterson for shoulder, left leg, and left hip pain. In March, 1987, claimant had three more treatments for these same problems. At his treatment on March 24, 1987, it was noted that he "still had leg pain on sitting."

Claimant was next seen by Dr. Peterson on April 7, 1987. It was noted at that time that his left leg pain, brought on by sitting, was still present. He was seen again on May 27, 1987, with the notation that his left leg pain was increasing, especially with sitting. This appointment began a series of evaluations and treatments during June, 1987, including a CT Scan on June 8, 1987 documenting a calcified herniated disc. A left L5-S1 lumbar diskectomy was performed on June 24, 1987. Claimant made no mention to any of his physicians of the April 1, 1987 incident.

FINDINGS OF ULTIMATE FACT

Claimant's herniated lumbar disc was not materially related to a work injury on April 1, 1989.

CONCLUSIONS OF LAW AND OPINION

The Referee decided the case based on the Supreme Court's holding in Runft v. SAIF, 303 Or 493 (1987). We disagree with the Referee's analysis because of our finding that the claim is not compensable.

The central issue on review is whether or not the Referee was correct in finding that claimant sustained a compensable injury on April 1, 1987, while the insurer was on the risk, which resulted in claimant's need for back surgery in June, 1987. The Referee's compensability ruling is based on this finding. We disagree with this finding and the Referee's conclusion that the claim is compensable.

Claimant failed to mention the April 1, 1987 incident in the 801 form. At hearing, he testified that he thought he had just wrenched his back and that he did not think much about it at the time.

To establish a compensable accidental injury claim, claimant has the burden of proving that a work incident was a material contributing cause of his subsequent disability or need for treatment. Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). The matter of the causation of claimant's calcified herniated disc and subsequent need for surgery is a complex medical question which requires supporting medical testimony. Uris v. Compensation Department, 247 Or 420 (1967).

Claimant sought treatment for his back only once during more than seven weeks following the alleged injury on April 1, 1987. At that time of treatment, he made no mention of the alleged injury and was reporting complaints very similar to those he had reported prior to the alleged injury. All the medical reports in evidence are of the opinion that claimant's need for treatment was related to a prior compensable injury and was not contributed to by any intervening injury or work activities. Claimant has failed to meet his burden of proof.

ORDER

The Referee's order dated December 28, 1987 is reversed. The insurer's denial is reinstated and upheld. The Board approves a client-paid fee, payable by the insurer to its counsel, not to exceed $1,516.

STANLEY W. TALLEY, Claimant
Douglas D. Hagen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-11371 & 87-16102
December 21, 1989
Order on Review

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Smith's order which: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability award for a low back condition from 20 percent (64 degrees), as awarded by Determination Order, to 60 percent (192 degrees); and (3) found claimant to be medically stationary as of May 7, 1987. The insurer, in its brief, contends that the increased award for permanent partial disability is excessive and that the Referee incorrectly set aside its denial of claimant's chiropractic treatments. The issues on review are premature closure, extent of permanent disability, including permanent total disability, and medical services. We affirm the Referee's order.

FINDINGS OF FACT

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

The treatments of Dr. Klingsberg have been ongoing twice weekly since May 1985. There has been no improvement noted.

Further back surgery is contra-indicated. In addition, as of May 7, 1987 there was no reasonable expectation that claimant's low back condition would materially improve with additional medical treatment or the passage of time. His permanent low back impairment is moderate.

As of May 7, 1987 there was no reasonable expectation that the neuroganglion of claimant's wrist would materially improve with additional medical treatment or the passage of time.

Claimant has made no claim for psychological problems related to his compensable injury. Claimant has not been treated for chemical dependency since 1986, nor is such treatment necessary at this time.

Dr. Klingsberg did not personally receive the employer's denial of medical services until January 1987. Claimant's treatments with Dr. Klingsberg are reasonable and necessary palliative services related to claimant's compensable injuries.

Claimant has not worked or looked for work since his part time job with Equitable Insurance in 1981.

Claimant's compensable low back injury and wrist injury do not physically preclude him from regularly performing gainful and suitable work. Nor do claimant's compensable physical conditions, when combined with social and vocational factors, preclude regular gainful employment.

Claimant has not established that he is willing to seek regular gainful employment. It would not be futile for claimant to seek work.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

A claim may be closed if claimant is medically stationary, i.e., no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). The Referee found that claimant was medically stationary when the claim was closed. We agree and adopt his opinion on that issue, with the following supplementation.

On review, claimant argues that his treating physician, Dr. Klingsberg, states that his low back condition is not medically stationary. The Referee did not find Dr. Klingsberg persuasive. He noted that Klingsberg had treated claimant for many years with no improvement by claimant. He further noted that Klingsberg proposed no new or different treatment. Instead, the Referee found the independent medical examiners and Dr. Field, an orthopedist who was recommended by Dr. Klingsberg, to be most persuasive. They all opined that claimant was medically stationary. For the reasons stated by the Referee, we, too, accept the opinions of the independent medical examiners and Dr. Field over that of Dr. Klingsberg.

Claimant next argues that he was not psychologically stationary at claim closure. Claimant has never made a claim for the compensability of a psychological condition. Moreover, while the Orthopaedic Consultants recommended claimant undergo a psychiatric examination, no physician has given or proposed treatment for a psychological condition. Nor has claimant shown disability due to a psychological condition. We conclude that claimant has failed to establish the presence of a compensable psychological condition requiring treatment.

By contrast, claimant's chemical dependency was found to be compensable in 1985. He began a drug and alcohol abuse program in 1986, but did not complete it because of financial problems and the onset of diabetes. However, claimant succeeded in combating his drug problems on his own and, at the hearing, he testified that he had not used drugs for months. We conclude that the Referee properly found claimant's chemical dependency condition to be medically stationary as of July 7, 1987.

Claimant also contends that his wrist condition was not medically stationary as of the date of closure. The July 7, 1987 Determination Order from which claimant requested a hearing, did not address the matter of claimant's wrist. It only made a determination of claimant's low back condition. Claimant's wrist condition appears to have arisen as the result of a separate injury which was the subject of another claim (Exs 0A and 0B). Consequently, the medical status of claimant's wrist condition is not a relevant consideration in determining whether the claim, which was the subject of the July 7, 1987 Determination Order, was prematurely closed.

In the alternative, even if we were to consider claimant's wrist condition, we would nevertheless conclude that

the condition was medically stationary as of July 7, 1987. In this regard, Dr. Field concluded that claimant's wrist was not likely to improve with surgical excision of the recurrent mass. To the contrary, he opined that surgery would not likely improve claimant's complaints or findings. We find his opinion persuasive, as did the Referee.

In conclusion, claimant has failed to sustain his burden of proof that he was not medically stationary as of July 7, 1987.

Extent of Permanent Disability

The Board adopts the opinion of the Referee with respect to the issue of extent of permanent disability, including permanent total disability.

Medical Services

The Board adopts the opinion of the Referee with respect to the issue of medical services.

ORDER

The Referee's order dated March 10, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $500 for services on Board review for prevailing on the issues raised in the insurer's brief. A client-paid fee, not to exceed $1,584, is approved.

ANN L. WAGENIUS, Claimant
Malagon, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 87-18846
December 21, 1989
Order on Review

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Fink's order that upheld the insurer's denial of her aggravation claim for an allegedly worsened low back condition. The issue on review is aggravation.

The Board affirms and adopts the Referee's order with the following supplementation.

A claimant is entitled to claim reopening under ORS 656.273 for worsened conditions resulting from the compensable injury. This worsening may be either temporary or permanent. Smith v. SAIF, 302 Or 396 (1986). Furthermore, this "worsening" must be established prior to expiration of claimant's aggravation rights. Perry v. SAIF, 93 Or App 631 (1988), rev'd on other grounds 307 Or App 654, on remand 99 Or App 52, n.2 (1989).

Here, no medical evidence exists concerning claimant's condition at the time of her claim, and before expiration of her aggravation rights. Therefore, the only evidence supporting her contention that her condition has worsened consists of her vague and noncredible testimony. Her testimony has neither substantiated a pathological nor symptomatic exacerbation of her compensable condition since the last award of compensation. Thus, we agree with the Referee that the denial of claimant's aggravation claim should be upheld. See Edward D. Lucas, 41 Van Natta 2272 (December 8, 1989).

ORDER

The Referee's order, dated February 17, 1988, is affirmed.

HARVEY BLAIKIE, Claimant
Malagon, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0481M
December 22, 1989
Own Motion Determination on Reconsideration

Claimant requests reconsideration of our December 8, 1988, Own Motion Determination that closed his claim with an award of temporary total disability benefits from June 29, 1987, through January 31, 1988, less time worked. Claimant contends that he is entitled to additional temporary disability benefits.

Temporary total disability compensation compensates claimant for loss of income due to a compensable injury until claimant's condition becomes medically stationary. Taylor v. SAIF, 40 Or App 437, 440, rev den 287 Or 477 (1979). Dr. Young, the treating physician, declared claimant medically stationary on August 29, 1988. In the absence of evidence to the contrary, we find that claimant became medically stationary as of that date. Consequently, claimant is entitled to temporary total disability benefits for income lost due to the compensable knee injury until August 29, 1988.

At the time of his original injury, claimant was earning $7.75 an hour as a logging equipment operator. When his knee condition worsened in 1987, claimant was working as a heavy equipment operator for a logging firm, specifically as a cat skinner and skidder operator. That employer subsequently went out of business. On November 9, 1988, Dr. Young released claimant for heavy equipment operation. Claimant was offered wage-subsidized employment as a logging tractor operator. However, when numerous delays postponed the start date for that employment, claimant obtained a cat operator position with another logging firm, commencing February 1, 1988 at an hourly wage of $12. Claimant successfully performed that job until his incarceration in jail sometime in March, 1988. Upon his release from jail in April, 1988, claimant returned to his former position as a cat operator. Shortly thereafter, the employer purchased new equipment with foot controls that exacerbated claimant's compensable knee condition, forcing him to leave work. Claimant remained off work through August 29, 1988, the medically stationary date.

Because claimant returned to regular work on February 1, 1988, at an hourly wage exceeding his wage at injury, his temporary disability benefits were completely offset by wages during that period of employment. Moreover, claimant's intervening period of incarceration does not alter the fact that claimant remained able to perform regular work at the same wage. Indeed, claimant returned to regular work upon his release from jail. Consequently, during the period of his incarceration, claimant is entitled to the same rate of temporary disability benefits to which he is entitled during employment, i.e., zero. However, claimant is entitled to temporary total disability benefits commencing on the date that he subsequently became disabled from work due to his compensable knee condition and continuing until the medically stationary date.

On reconsideration, our December 8, 1988, order is amended to award temporary total disability from June 29, 1987, through August 29, 1988, less time worked and time in incarceration.

Claimant's attorney is entitled to a reasonable attorney fee payable out of increased compensation awarded by this order. However, we cannot approve a fee unless claiamnt's attorney files an executed retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

Accordingly, our December 8, 1988, order is abated and withdrawn. As amended herein, we adhere to and republish our December 8, 1988, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

Cite as 41 Van Natta 2399 (1989)

In the Matter of the Compensation of LOUIS A. DUCHENE, Claimant

WCB Case No. 87-10437
ORDER ON REVIEW
December 22, 1989
Emmons, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of those portions of Referee Borchers' order that: (1) set aside its aggravation denial of claimant's allegedly worsened low back condition; and (2) awarded 35 percent (112 degrees) unscheduled permanent disability for the same condition. On review the issues are aggravation and extent of unscheduled permanent disability.

The Board affirms the order of the Referee.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

In November, 1987, claimant suffered a symptomatic flare-up of his compensable low back condition as a material result of the November, 1985, injury, which rendered him less able to work than at the time of June, 1987, Determination Order.

At the time of the hearing, claimant's low back condition was medically stationary.

Claimant has mildly moderate permanent physical impairment of his compensable low back condition.

CONCLUSIONS OF LAW

Aggravation

To establish an aggravation, the worker must prove a worsened condition resulting from the compensable injury. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986). In order to establish a "worsened condition", claimant must show that he has experienced either a pathological worsening or a symptomatic exacerbation resulting in diminished earning capacity. Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989). If a worsening involves a symptomatic exacerbation, and if the prior award contemplated symptomatic exacerbations, then claimant must also prove that: his earning capacity was diminished longer or in greater degree than was anticipated; or that his earning capacity resulted in 14 consecutive days of total disability or inpatient hospitalization. Gywnn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (December 8, 1989).

Claimant, a 28 year-old veneer puller, compensably injured his low back in November, 1985. After one month, he returned to modified work -- alternating between light and heavy duties. Since September, 1986, however, he has primarily performed only light duties. A Determination Order closed his claim in June, 1987, with no award of permanent disability. The following month, claimant suffered a flare-up of low back pain and was examined at a hospital emergency room. A few days later, he sought treatment from Dr. Sims, a neurosurgeon. Sims treated with anti-inflammatories and recommended continued light duty work. Dr. Tsai, M.D., concurred with Sims' light duty release.

In October, 1987, claimant began to treat with Dr. Foster, a chiropractor. Foster found no objective pathology at that time and released claimant to regular work without restriction. After one week on-the-job, claimant returned to Foster with renewed complaints of pain. Foster treated conservatively, but claimant's condition continued to deteriorate.

On November 10, 1987, claimant filed an industrial injury claim form for an "irritated low back." A few days later, he returned to Foster. Foster recommended a back brace and restricted him from bending, twisting, or lifting beyond 20 pounds. According to Foster:

"[Claimant's] condition is likely to be aggravated whenever he does this type of work that he has been doing recently. Namely lifting and twisting, I think he is going to probably be unable to return to this type of work. At the present time [I] do not have anything that I think will materially improve his subjective feelings of pain and I think [a] job change is probably the only thing that will give him benefit."

Claimant was examined by Dr. Mandinberg in January, 1988. Mandinberg found "no evidence of permanent impairment" and opined that claimant's complaints were a "continuation" of the November, 1985, injury. The following month, the insurer denied claimant's new injury claim, contending that his complaints were related to the compensable November, 1985, injury. In response to Mandinberg's opinion, Foster stated that he "found no evidence that [claimant] will be able to return to his previous jobs * * * without experiencing the pain he has noted in the past." At the hearing, claimant credibly testified that he did not feel he could return to any of his prior jobs, save for, perhaps, cannery work.

When the medical evidence is divided, we must choose the correct medical hypothesis. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). In the absence of persuasive reasons to do otherwise, we generally accord greater weight to the opinion of a worker's treating doctor. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, we are persuaded by Foster's opinion. Neither Sims nor Tsai rendered an opinion concerning claimant's symptomatic flare-up in November, 1987. We, therefore, find that their opinions are of little value in assessing whether claimant's condition worsened as of that date. As to Mandinberg, he viewed claimant on only one occasion. In contrast, Foster observed claimant on several occasions, as well as both before and after the November, 1987, flare-up. See Kienow Foods v. Lyster, 79 Or App 416, 421 (1986).

The insurer argues that under Gwynn, supra, claimant has not proven an aggravation because he was neither totally disabled for more than 14 days nor underwent inpatient hospitalization. See Gwynn, 304 Or at 353. We do not agree with the insurer's argument. After Gwynn, the Court announced in Perry, supra, that a worsened condition was a "factual question." 307 Or at 657. Here, claimant's November, 1987, flare-up resulted in new and significant permanent restrictions and an inability to continue working. Moreover, since at the time of the last award of compensation, the June 1987 Determination Order, claimant had not been awarded permanent disability, no future waxing and waning of symptoms would have been contemplated. Accordingly we find that claimant sustained a compensable aggravation of his low back condition in November, 1987.

Extent of Unscheduled Permanent Disability

In analyzing claimant's extent of disability, the Referee cited to Gwynn, supra, and discussed whether the June, 1987, award contemplated future symptomatic flare-ups. Although we agree with the Referee's award of 35 percent unscheduled permanent disability, we do so for different reasons.

Gwynn has little application to the issue of whether claimant is entitled to an award of unscheduled permanent disability. Gwynn addresses the issue of aggravation; not extent of unscheduled permanent disability. "Moreover, Gwynn only applies where the last arrangement of compensation anticipated future symptomatic flare-ups resulting in diminished earning capacity." To prove entitlement to an award of unscheduled permanent disability, a worker must prove a permanent loss of earning capacity in the broad field

of general occupations due to the compensable injury. ORS 656.214(5). In determining loss of earning capacity, we consider the worker's physical impairment, his testimony, and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply the Department's rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Claimant is 28 years of age and educated through one year of college. His employment experience consists almost entirely of work in heavy labor occupations. At the time of the hearing, he had not returned to work. As a result of his compensable injury, he has been permanently foreclosed from both medium and heavy work. He is permanently restricted from bending, twisting, or lifting in excess of 20 pounds and is unable to return to nearly all of his former types of employment.

Although Mandinberg opined that claimant was without permanent impairment, we have found above that we are more persuaded by Foster's opinion. Based on claimant's permanent work restrictions, as set forth by Foster, and his credible testimony of pain, we conclude that his pain is disabling, see Harwell v. Argonaut, 296 Or 505 (1984), and has resulted in moderate permanent impairment. After considering claimant's impairment, his age, his education, and his lack of experience or training in light occupations, we agree with the Referee that an award of 35 percent unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity.

ORDER

The Referee's order, dated April 18, 1988, as amended May 13, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $630, to be paid by the insurer. The Board approves a client-paid fee not to exceed $2,274.50.

GERALD J. HOLMES, Claimant
Robert Chapman, Claimant's Attorney
Charles Lisle (SAIF), Defense Attorney

WCB 86-03668
December 22, 1989
Second Order on Reconsideration

We issued on Order on Review in this matter on November 20, 1989 and an Order on Reconsideration on December 8, 1989. At this time, we reconsider on our own motion to clarify and supplement our prior orders.

This matter arose initially when, on February 12, 1989, the noncomplying employer (NCE) filed a request for hearing from a January 28, 1986 Proposed and Final Order; Notice declaring it to be a noncomplying employer. That request for hearing also raised the issue of the compensability of claimant's claim of injury. On March 25, 1986, SAIF, as processing agent for the NCE [See ORS 656.054(1)], issued a Notice of Claim Acceptance. The NCE spoke with a SAIF representative by telephone and was advised that its February, 1986 request for hearing was sufficient to place the issue of compensability and of SAIF's March, 1986 acceptance into issue at hearing. As a result, the NCE did not file a request for hearing from SAIF's Notice of Claim Acceptance until September 19, 1986, after the NCE's attorney became involved.

On October 2, 1987, a hearing was held. Claimant and the NCE were present and represented by their attorneys. SAIF waived appearance. Claimant did not object to the NCE's February, 1986 request for hearing, as it related to the compensability of claimant's claim, as being premature. Neither did claimant object to the NCE's September, 1986 request for hearing from SAIF's Notice of Claim Acceptance as being untimely.

The Referee issued an Opinion and Order in this matter on November 27, 1987. Implicit in that order was a finding that the Referee had jurisdiction over the question of the compensability of claimant's asserted claim. The Referee found that claimant had suffered a compensable injury and that the

employer was subject and noncomplying. The January 28, 1986 Proposed and Final Order; Notice was affirmed and SAIF's acceptance of the claim was approved.

After abating the November 27, 1987 Opinion and Order, the Referee issued an Opinion and Order on Reconsideration on January 15, 1988. He made supplemental findings and concluded that the employer was not a subject employer and that claimant had suffered a "work-related" injury. He set aside the Proposed and Final Order; Notice but made no disposition of SAIF's Notice of Claim Acceptance. Claimant requested Board review from the January 15, 1988 Opinion and Order on Reconsideration.

We reconsider, in part, to examine our jurisdiction. We find that the Referee in this matter did have jurisdiction of the issue of the compensability of claimant's injury claim. The NCE placed that matter in issue by its February, 1986 and September, 1986 requests for hearing. No objection to those requests for hearing was made by any other party. The issue was fully litigated at hearing. See Thomas v. SAIF, 64 Or App 193 (1983). On review, no party challenged the Referee's jurisdiction over the issue of the compensability of claimant's injury claim.

The order declaring this employer to be a NCE was properly contested at the same hearing as a matter concerning the compensability of claimant's claim. For that reason, we have jurisdiction over this matter on review. ORS 656.740(4)(c).

In our November 20, 1989 Order on Review we found that the employer had failed to prove that the Director's Proposed and Final Order; Notice was incorrect. ORS 656.740(1). We reinstated the Director's order. However, we failed to address the status of SAIF's Notice of Claim Acceptance. We reconsider our prior orders, in part, to do so. Since that acceptance has never been formally set aside, we need only affirm that acceptance.

Accordingly, SAIF's March 25, 1986 Notice of Claim Acceptance is affirmed. In conclusion, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 20, 1989 Order on Review and our December 8, 1989 Order on Reconsideration. The parties' rights of appeal shall run from the date of this order.

TIM L. MORLOCK, Claimant
Barbara A. Brainard (SAIF), Defense Attorney

WCB 88-02454
December 22, 1989
Amended Order on Review (Remanding)

The Board issued an Order on Review (Remanding) in the above captioned matter on December 15, 1989. On our own motion, we hereby withdraw our December 15, 1989, order in its entirety, and issue the instant Amended Order on Review (Remanding), effective this date.

Specifically, it has come to our attention that we utilized incorrect dates in referring to the Referee's Order of Dismissal and claimant's letter requesting reinstatement of his request for hearing. The correct dates are as follows. The Referee's Order of Dismissal is dated May 18, 1988. Claimant's letter was sent by regular mail. His letter is handwritten and undated. Nonetheless, it was physically received and, therefore, filed with the Board on June 1, 1988.

Claimant, pro se, requests review of Referee Thye's order that dismissed his request for hearing. On review, the issue is dismissal. We vacate and remand.

FINDINGS OF FACT

Prior to the hearing, claimant's attorney wrote a letter to the Referee indicating that claimant's employer had threatened to fire him if he attended the hearing. Wishing to avoid being fired, claimant informed his attorney that he would not attend the hearing. Claimant understood that failing to appear at the hearing would result in a dismissal of his hearing request.

A few days later, the Referee entered an Order of Dismissal, dated May 18, 1988. The dismissal order stated: "The Request for hearing in this matter has been withdrawn. Accordingly, the matter is dismissed."

Shortly thereafter, claimant's attorney apparently withdrew his representation. On June 1, 1988, claimant filed the following handwritten note addressed to the Workers' Compensation Board:

> "Dear Sirs,
>
> I would like to request of my case a new review.
>
> I was unable to attend the last date due to my work schedule. Please issue me a new hearing date."

CONCLUSIONS OF LAW

The Hearings Division retains jurisdiction over a request for hearing for 30 days following the issuance of an Order of Dismissal, unless a request for Board review is filed prior to that time. See ORS 656.289(3).

Given that claimant was apparently no longer represented at the time he filed his letter of June 1, 1988, and that 30 days had not elapsed following the issuance of Order of Dismissal, we conclude that the Referee should have ruled on claimant's request for postponement of the original hearing and reinstatement of his hearing request. See Mark R. Luthy, 41 Van Natta 2131 (November 21, 1989). Accordingly, we remand this case to the Referee.

ORDER

The Referee's order, dated May 18, 1988, is vacated. This case is remanded to Referee Thye with instructions to entertain claimant's request for reinstatement. If the Referee should determine that claimant's hearing request should be reinstated, then claimant's letter filed with the Board on June 1, 1988, should be submitted to the Hearings Division for processing as a request for hearing.

In the Matter of the Compensation of MICHAEL W. PHILLIPS, Claimant

WCB Case No. 86-12963
ORDER ON REVIEW
December 22,1989
Francesconi & Associates, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Baker's order which upheld the self-insured employer's denial of his injury claim for a heart attack. We affirm.

ISSUES

The issue is compensability of the heart attack. Claimant contends that the Referee erred in concluding that the employer had overcome the fireman's presumption by clear and convincing evidence. The employer argues that the Referee should not have applied the fireman's presumption, but that even if applying the presumption was proper, it overcame the presumption by clear and convincing evidence.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant worked as a firefighter for this employer for more than five years. Before his heart attack claimant had been examined by doctors; these examinations revealed no evidence of a heart condition which preexisted his employment. Claimant suffered a heart attack off the job on July 6, 1986.

Claimant's work did not contribute to his heart attack.

CONCLUSIONS OF LAW AND OPINION

Former ORS 656.802(1)(b) and (2) is applicable to this case. It provides that if a claimant has worked as a firefighter for more than five years and has had a physical examination at time of hire or thereafter which fails to reveal evidence of a preexisting heart problem, then the heart condition is presumed to be a compensable occupational disease. The fireman's presumption has the weight of evidence. Wright v. SAIF, 289 Or 323 (1980). Under the applicable statute, the employer/insurer then has the burden of proving by clear and convincing evidence that claimant's work did not cause his heart attack.

The employer argues that claimant did not have a complete physical so he has failed to satisfy one of the elements required to invoke this presumption. The Referee found that claimant had sufficiently satisfied the physical examination element. We agree. While it is true that claimant had no complete physical examination, he did see doctors several times and those examinations revealed no heart disease. Of particular importance is the fact that claimant had a stress test in January 1986 which failed to reveal any heart problems. Accordingly, we conclude that the fireman's presumption is applicable.

Claimant argues that the Referee erred in concluding that the opinions of the treating physician and two independent medical examiners are sufficient to meet the clear and convincing test. We agree with the Referee. The three doctors all state that the work did not cause the heart attack. Despite claimant's counsel's attempts to weaken the positions of the treating physician and one of the independent examiners in depositions, the opinions of the two doctors did not change. Furthermore, they convincingly explained the basis for their opinions. We conclude that their opinions provide clear and convincing evidence that claimant's work did not cause his heart attack.

ORDER

The Referee's order dated February 9, 1988 is affirmed. A client-paid fee, not to exceed $894, is approved for counsel for the employer.

SUSIE F. RAGAN, Claimant
Roberts, et al., Defense Attorneys

WCB 83-09449
December 22, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Braverman's order that upheld the self-insured employer's denial of claimant's aggravation claim for a right wrist condition. On review, the issue is whether claimant's current condition is causally related to her 1980 compensable injury and, if so, whether her condition has worsened since the last award of compensation.

The employer has moved for dismissal of claimant's request for review, contending that she has "abandoned" her appeal. The motion is denied. Inasmuch as claimant's request for review has been submitted timely and since copies have been timely provided to the other party to the proceeding, we have jurisdiction to consider this case. See Linnie L. Lockwood, 41 Van Natta 846, 847 (1989) (Failure to submit an appellant's brief and to secure substitute legal counsel does not result in dismissal of request for review for "abandonment").

We turn to the merits. After conducting our review of the medical and lay evidence, we agree with the Referee's ultimate conclusion that claimant has failed to establish that her current need for a right wrist fusion is causally related to her 1980 compensable right wrist injury. Accordingly, we affirm and adopt that portion of the Referee's order. In so doing, we render no opinion concerning the Referee's discussion of res judicata.

ORDER

The Referee's order dated July 26, 1984 is affirmed. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $1,000.

DONALD C. ROSACKER, Claimant
Vick & Gutzler, Claimant's Attorneys
Tony Pizzuti, Attorney
Richard McGinty, Attorney

WCB 87-19737
December 22, 1989
Order of Dismissal

Claimant requests review of Referee Hayduke's order that set aside the order of the Workers' Compensation Department finding that the employer was a noncomplying employer. We dismiss the request for review for lack of jurisdiction.

FINDINGS OF FACT

On November 25, 1987, the Director issued Proposed and Final Order; Notice declaring that Nikita A. Kaya was doing business as a sole proprietorship, which was a noncomplying employer. On December 9, 1987, the employer requested a hearing on the Notice of Proposed and Final Order. By letter dated December 11, 1987, the SAIF Corporation informed the employer that claimant's claim had been accepted. No request for hearing was filed with respect to that acceptance. A hearing was held before the Referee concerning the Director's order of noncompliance. Evidence was admitted on the issue of noncompliance. Thereafter, the Referee set aside the Director's order. The Referee's order concludes in part:

"NOTICE TO ALL PARTIES: If you are dissatisfied with this Order, you may, within thirty (30) days after the mailing date of this Order, request a review by the Worker's Compensation Board...."

CONCLUSIONS OF LAW

If any party requests a hearing on a Director's proposed order regarding noncompliance or any other matter unrelated to a claim, the Board appoints a Referee to hold a hearing. ORS 656.283(4); Heinz J. U. Sauerbrey, 37 Van Natta 1512 (1985). That is the Board's only involvement in cases such as this. When a Referee issues an order, it is then a final order of the Director and must be appealed directly to the Court of Appeals. ORS 656.740(4); ORS 183.480(1)(2); see Stanley Wilson, 40 Van Natta 387 (1988).

The employer's request for hearing related solely to the issue of noncompliance. Because the Referee's order solely concerned the noncompliance issue, the Board does not have jurisdiction over claimant's request for review. Since we lack jurisdiction to review the Referee's order, the appeal must be dismissed.

It is regrettable that the Referee's statement of appeal rights may have misled the parties. However, our jurisdiction is statutory and an incorrect statement of appeal rights cannot expand or contract that jurisdiction. See Gary O. Soderstrom, 35 Van Natta 1710 (1983).

Accordingly, the request for Board review is dismissed.

MICHAEL P. STENASI, Claimant
Vick & Gutzler, Claimant's Attorneys
Rick Dawson (SAIF), Defense Attorney
Nelson, et al., Defense Attorneys

WCB 89-18752 & 88-17280
December 22, 1989
Order of Dismissal (Remanding)

The SAIF Corporation has requested Board review of Referee Schultz's order dated December 1, 1989. Liberty Northwest Insurance Corporation has moved to dismiss SAIF's request, contending that jurisdiction rests with the Hearings Division. We agree. Consequently, we dismiss and return the case to the Referee.

FINDINGS OF FACT

The Referee's order issued December 1, 1989. On December 11, 1989, the Referee abated his order to consider Liberty Northwest's motion for reconsideration. That same day, SAIF requested Board review of the Referee's order.

CONCLUSIONS OF LAW

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. James D. Whitney, 37 Van Natta 1463 (1985).

Inasmuch as the Referee abated his order simultaneously with SAIF's request for Board review, we shall give effect to the abatement order. Accordingly, the request for review is dismissed as premature. The file is returned to Referee Schultz, who retains jurisdiction for further consideration of this case.

IT IS SO ORDERED.

In the Matter of the Compensation of KAREN WHEELER, Claimant

ORDER ON REVIEW
December 22, 1989
WCB Case No. 87-00115
Kirkpatrick & Zeitz, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Podnar's order that affirmed awards by Determination Order and stipulation of 50 percent (160 degrees) unscheduled permanent disability for a low back condition. The issue on review is extent of permanent disability following aggravation, including permanent total disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

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

Claimant complained of right leg and knee pain as early as 1983, and of right side pain in 1984.

The stipulation referenced in paragraph six, page two of the Referee's order was signed in February 1985.

FINDINGS OF ULTIMATE FACT

The February 1985 stipulation was claimants last arrangement of compensation.

Claimant has not sustained permanent diminished earning capacity since the February 1985 stipulation.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's conclusions and opinion with the following supplementation.

The Referee concluded that claimant had sustained a compensable aggravation of her low back condition, and the self-insured employer is not contesting that ruling. Therefore, claimant has established at least a temporary worsening of her condition since the last arrangement of compensation by stipulation in February 1985. She must now prove that her worsening is permanent, so that she is entitled to reevaluation of her permanent disability award. Stepp v. SAIF, 304 Or 375 (1987). The Referee concluded that claimant had not carried her burden of proof on this issue. We do not entirely agree with the Referee's analysis, but we affirm his ultimate ruling.

Like the Referee, we give little weight to claimant's testimony regarding her subjective complaints. However, we do so for a different reason. The Referee concluded that claimant's testimony was credible, but not persuasive. We conclude that claimant was neither credible nor persuasive. She testified that
she first began experiencing right side/leg pain sometime after 1985. However, the medical record indicates that claimant complained of right leg and knee pain as early as 1983, and of right side pain in 1984. Furthermore, claimant's alleged onset of right side/leg pain after 1985 is not supported by the medical record. Claimant was examined by Dr. Nelson, D.O., in August 1986, and by Dr. Baum, D.O., in August 1987. At neither of these examinations did she make any reference to right side/leg pain. Dr. Nelson found her condition radiologically unchanged from studies done in 1982 and 1983. Dr. Baum found claimant to be medically stationary. For these reasons, we give little weight to claimant's testimony regarding her subjective complaints.

We also give little weight to the medical evidence supporting claimant's position. The only medical opinion supporting a worsening is from treating physician Leveque, D.O. In November 1986, he opined that claimant had experienced a progressive worsening of her condition. However, his license to practice medicine in this state has been revoked, and he has been placed on a ten-year probation period. Furthermore, his

opinion is based on claimant's report of her subjective complaints, which is neither credible nor persuasive. For these reasons, Dr. Leveque's opinion is entitled to little weight. See Phillip J. Barrett, 38 Van Natta 436, 439 (1986).

We, therefore, conclude that claimant has not demonstrated a permanent worsening of her condition since the February 1985 stipulation. Accordingly, we agree with the Referee's conclusion that claimant is not entitled to reevaluation of her permanent disability.

ORDER

The Referee's order dated September 29, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $765.

DEBRA L. STOWELL-KING, Claimant
Royce, et al., Claimant's Attorneys
Terrall & Miller, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-18325 & 87-13263
December 26, 1989
Order on Review

Reviewed by Board Members Myers and Cushing.

Jantzen, Inc., a self-insured employer, requests review of Referee Hoguet's order which: (1) set aside its denial of claimant's claim for her left carpal tunnel syndrome; and (2) upheld Liberty Northwest's denial of claimant's claim for the same condition. On review the issue is responsibility. We reverse.

FINDINGS OF FACT

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

Claimant filed a claim in February, 1983, contending that her right hand pain and swelling was related to her work activities as a power sewing machine operator for Jantzen. The claim was accepted in April, 1987. A right carpal tunnel decompression was performed on May 12, 1983. By Determination Order of March 5, 1984, claimant received 5 percent (7.5 degrees) scheduled permanent disability for loss of her right forearm. An October 3, 1985, stipulation increased this award to 15 percent.

On April 1, 1987, claimant began working for Liberty's insured as a Certified Nurse's Assistant. She worked 40 hours a week caring for invalid patients which involved rigorous arm and hand movements -- lifting patients, many of them heavy, from beds to wheelchairs to toilets and back to beds, and making 20 or more beds a day. On June 2, 1987, claimant filed an 801 Form describing an injury to her "left arm/hand," stating that it was a recurrence of "old injury in 83," and that it happened while "lifting + handling patients." (Ex. 59). At that time, claimant experienced excruciating pain in her left hand radiating up through her left shoulder while lifting a patient. This was the first time that she had ever experienced such pain in her left shoulder (Tr. 30).

Claimant's family physician performed nerve conduction studies and requested the reopening of her claim and authorization for a left carpal tunnel release in June, 1987. (Ex. 61A-2). Dr. Button, on August 10, 1987, diagnosed the condition as symptomatic left carpal tunnel syndrome. (Ex. 62-3). Because of her left hand/arm condition, claimant was not able to return to work for Liberty's insured. (Tr. 18). Left carpal tunnel release was performed on February 24, 1988.

Both carriers denied responsibility for claimant's left arm claim. No order designating a paying agent pursuant to ORS 656.307 issued. However, at the hearing the carriers conceded the compensability of the claim.

Claimant experienced some left hand and arm problems while working for Jantzen. (Ex. 11-5). In addition, Dr. Nathan, a hand surgeon, noted that claimant's left hand was showing evidence of carpal tunnel disease in May, 1983. (Ex. 15-3). However, Claimant suffered no disability nor received treatment for her left hand prior to filing her June, 1987 claim while Liberty's insured was on risk.

Dr. Button, M.D., a hand surgeon, evaluated the claimant's condition in August, 1987. Dr. Nathan, M.D., a hand surgeon, who had examined claimant back in 1983, reexamined claimant in October, 1987.

ULTIMATE FINDING OF FACT

Claimant's left hand/arm condition became disabling in June, 1987, while she worked for Liberty's insured.

Claimant's employment at both Jantzen and Liberty's insured were each capable of causing claimant's need for medical treatment and disability for her left carpal tunnel condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had sustained a left carpal tunnel condition from her employment at Jantzen. The Referee held that claimant's work exposure at Liberty's insured did not independently contribute to a worsening of claimant's underlying left carpal tunnel condition, but that claimant's symptoms reappeared after she started working for Liberty's insured and that her subsequent employment produced a symptomatic episode.

If we are convinced that claimant's left carpel tunnel disability was caused by the successive work-related conditions but are unconvinced that any one employment is the more likely cause of her disability, then the last employment providing such conditions is deemed to have caused the disability. Bracke v. Baza'r, 293 Or 239 (1982). The onset of disability is the triggering date for determination of which employer is the "last potentially causal employer." Bracke v. Baza'r, 293 Or at p. 248. In order to shift responsibility to an earlier employer, it must be established that the work conditions with the earlier employer were the sole cause or that it was impossible for work conditions with the last employer to have caused the disability. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (1985).

After conducting our review of the medical and lay evidence, we are not persuaded that either employment exposure was the more likely cause of claimant's left wrist disability. What is more, the medical reports and claimant's testimony support the conclusion that claimant's employment conditions at Jantzen were capable of causing claimant's left hand/arm problem which was eventually diagnosed as left carpal tunnel syndrome. Moreover, claimant's employment at Liberty's insured also exposed her to conditions that could have caused the left carpal tunnel syndrome.

Inasmuch as we are not persuaded that either one of claimant's work-related exposures was more likely to have caused her disability than the other, we turn to a determination of which employer is the "last potentially causal employer." As previously noted, the key event for determining responsibility in an occupational disease setting is the date of disability. Bracke, supra, 293 Or at 247-49 (1982). Here, claimant was disabled as of June 2, 1987, when she was released from work as a result of excruciating pain in her left hand. Thereafter, she was unable to work because of her left carpal tunnel surgery. Thus, Liberty's insured, which provided conditions capable of causing claimant's left carpal tunnel syndrome, was the last potentially causal employer.

Liberty contends that the onset of disability for claimant's left wrist occurred while claimant was working for Jantzen. Specifically, Liberty asserts that claimant sought medical treatment for her left wrist complaints and received a diagnosis of bilateral carpal tunnel syndrome. We disagree with Liberty's contentions.

To begin, although the medical record contains an occasional reference to left wrist complaints while claimant was working for Jantzen, no specific treatment for the complaints is mentioned. In any event, the date a claimant first sought medical treatment is relevant in determining a disability date only where the disability has not resulted in time loss. Inkley v. Forest Fiber Products Corp., 288 Or 307 (1980); SAIF v. Carey, 63 Or App 68 (1983). Inasmuch as claimant first lost time from work as a result of left wrist disability in June, 1987, we conclude that that is the date of disability for purposes of determining responsibility for the claim.

Since claimant's work activities with Liberty's insured could have caused her left carpal tunnel syndrome and because she did not become disabled until she engaged in such activities, we find that Liberty's insured was the last potentially causal employer. Accordingly, Liberty's insured is deemed to be responsible for claimant's left carpal syndrome claim.

ORDER

The Referee's order, dated June 10, 1988, is reversed. Jantzen's denial is reinstated and upheld. Liberty Northwest's denial is set aside and Liberty shall process the claim according to law. The Board approves a client-paid fee, not to exceed $773 payable from Liberty Northwest to its counsel. The Board approves a client-paid fee not to exceed $3,853, payable from Jantzen to its counsel. For services on review, claimant's attorney is awarded an assessed fee of $50, to be paid by Liberty Northwest.

KATHLEEN M. DAVIS, Claimant	WCB 87-17179
Leistner, et al., Claimant's Attorneys	December 27, 1989
Schwabe, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Livesley's order that: (1) upheld the insurer's denial of her claim for a right knee condition; and (2) declined to assess a penalty and associated attorney fee for alleged unreasonably denial. The issues on review are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the finding regarding claimant's reliability as a witness.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not a reliable witness based upon alleged "great inconsistencies" between claimant's depiction of her right knee condition and the histories given to the doctors. On review, claimant argues that the Board should reject the Referee's finding regarding her unreliability.

However, we conclude that we need not address the reliability question because, even accepting claimant's testimony as reliable, claimant's evidence is insufficient to sustain her burden of proving compensability. In this regard, the only physician whose opinion supports her claim is Dr. Orwick. He stated that "[m]y opinion is that more than likely her right knee pain is due to an over use phenomenon related to her job."

The Referee rejected Dr. Orwick's opinion, in part, on the basis of his conclusion that Dr. Orwick's opinion is insufficient to establish the requisite causal relationship. We agree. While it is clear that Dr. Orwick believes claimant's work to be a contributing factor to her condition, it is unclear whether he felt that claimant's work was the "major cause" of that condition. And yet, in order to establish the compensability of her claim, it is necessary for claimant to prove that her work activities and exposures were the major cause of the onset or a worsening of her condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

In addition, Dr. Orwick did not first examine claimant until three months following the onset of her condition. He then based his opinion upon a history of "quite a bit of squatting and kneeling." The evidence does not establish that claimant did any kneeling during the day. In addition, based upon claimant's statements, on average she squatted four or fewer times per work hour. In addition, Dr. Orwick's report does not indicate any awareness of claimant's off-work activities. Therefore, we are unable to find that Orwick had an accurate understanding of either claimant's work or her off-work activities. Consequently, his opinion regarding causation lacks persuasiveness. Somers v. SAIF, 77 Or App 259, 263 (1986).

By contrast, Dr. Schroeder examined claimant closer in time to the onset of her symptoms. He is an orthopedic surgeon. Claimant was referred to him by her treating physician, Dr. Jones. Schroeder opined several times that claimant's condition was unrelated to her work activities. Dr. Jones indicated that he would defer to Dr. Schroeder's opinion with regard to claimant's knee condition.

In light of the relative unpersuasiveness of Dr. Orwick's opinion, and the contrary opinion of Dr. Schroeder, we conclude that claimant has failed to sustain her burden of proof.

ORDER

The Referee's order dated May 5, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $1,248.

SANTOS ESPINOSA, Claimant	WCB 87-13803
Vick & Gutzler, Claimant's Attorneys	December 27, 1989
John Motley (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Hettle's order that granted claimant an award of permanent total disability, whereas prior Determination Orders awarded a total of 75 percent (112.5 degrees) scheduled permanent disability for loss of use of the left forearm. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

Claimant, a 42-year-old former tree trimmer, was struck in the left arm by a chain saw in June, 1979, resulting in a compensable injury. The injury caused extensive nerve damage. Plastic and reconstructive surgery was performed by Drs. Jarrett and Schachner, surgeons. The surgery also involved the implantation of a plate in claimant's forearm and wrist to fixate the ulna. Despite the surgery, claimant was left with a "claw" hand. After several months of physical therapy, his left arm and hand became medically stationary in February, 1985.

A Determination Order closed claimant's claim in April, 1980, with an award of 50 percent scheduled permanent disability for the loss of use or function of the left arm.

In December, 1983, claimant began to treat with an orthopedist, Dr. Morales. EMG studies revealed complete denervation of some muscles in the left hand. Claimant had weakness and atrophy in all other muscles of the left forearm and hand, a claw deformity of the left hand, no motor or sensory function of the ulnar nerve below the forearm and reduced subjective sensation in the median nerve (ex. 18, 20 & 27).

Claimant's claim was not reopened for time loss but, in April, 1984, a Determination Order awarded an additional 25 percent scheduled permanent disability, for a total award of 75 percent. That Determination Order was affirmed by a June, 1984, Determination Order.

In July, 1984, claimant fractured his left radius. Dr. Spady, an orthopedist, placed claimant in an arm cast. The following month, claimant began to treat with Dr. Layman, a plastic surgeon. To improve the sensory ability in claimant's small and ring fingers, Layman performed ulnar nerve graft surgery in September, 1984. Claimant experienced regeneration of the ulnar nerve, into the palm of his hand, but not into his fingers (ex. 33-50).

Vocational evaluation was undertaken in April, 1985, at the Callahan Center. Initial examinations at the Center revealed limited work skills, a slow work pace, and a need for a high amount of employer assistance and structure. In October, 1985,

return-to-work efforts were commenced by Norma Matias, a vocational counselor.

In the Fall of 1985, Layman referred claimant to Dr. Young, an orthopedist. Young performed additional surgery in June, 1987, to remove the broken plate. He declined, however, to surgically repair the non-union of the left ulna insofar as claimant's forearm pain had nearly resolved. The following month, claimant's left arm and hand condition became medically stationary. An August, 1987, Determination Order awarded no additional scheduled permanent disability, beyond the 75 percent previously awarded.

CONCLUSIONS OF LAW

Finding that claimant had established a permanent worsening of his left arm/hand condition, the Referee granted an award of permanent total disability. We disagree.

When the issue of permanent total disability is before the trier of fact by way of a worker's compensable aggravation that has resulted in a redetermination of his permanent disability, as here, the trier of fact must initially consider whether the worker has proven a permanently worsened condition since the last arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987).

We are not persuaded that the medical and lay evidence establishes a permanent worsening of claimant's condition since the June, 1984, arrangement of compensation. He is, therefore, not entitled to an award of permanent total disability.

Claimant had a severely disabled left forearm and hand before the last arrangement of compensation; i.e., the June, 1984, Determination Order. In September, 1984, Dr. Layman grafted claimant's severed left ulnar nerve. Claimant subsequently experienced a regeneration of six inches or more of that nerve. Immediately before the August 1987 Determination Order issued, claimant had a near complete resolution of left forearm pain. His general left forearm and hand condition was otherwise unchanged, although tests for ranges of arm, wrist, and finger motions showed variable improvement or worsening at various times (compare Exs. 29, 35, 54 & 82). Moreover, although claimant testified as to his present condition, he made no comparison to his condition in June, 1984. We have no persuasive basis for finding a permanent worsening of subjective symptoms resulting from his compensable injury.

Accordingly, we conclude that claimant has not met the threshold requirement of proving a permanently worsened condition since the last arrangement of compensation. He is, therefore, not entitled to additional permanent disability compensation.

ORDER

The Referee's order, dated October 27, 1988, is reversed. In lieu of the Referee's award of permanent total disability, the August 31, 1987, Determination Order is affirmed.

KAREN L. NICKOLS, Claimant
Black, et al., Claimant's Attorneys
Nelson, et al., Defense Attorneys
Cowling & Heysell, Defense Attorneys

WCB 87-12634 & 87-14706
December 27, 1989
Order on Review

Reviewed by Board Members Howell and Speer.

The insurer requests review of those portions of Referee Emerson's order that: (1) set aside its "new injury" denial for claimant's low back condition; and (2) awarded claimant's attorney an assessed fee for setting aside its denial. On review, the issues are responsibility and attorney fees.

The Board affirms and adopts the order of the Referee with the following comment. The insurer in this case is the carrier for both employers. Prior to the hearing, the insurer rescinded its aggravation denial on behalf of the earlier employer. Inasmuch as its rescission resulted in an acceptance of claimant's aggravation claim, the insurer argues that claimant was estopped from proceeding to hearing and attempting to prove a "new injury" against the later employer. We, like the Referee, disagree with the insurer's argument.

The Hearings Division has jurisdiction over any matter concerning a claim. ORS 656.283(1). There is no dispute that claimant filed a claim against the later employer and requested a hearing from its denial. Furthermore, by proceeding to hearing under a "new injury" theory, a new five year period of aggravation rights, ORS 656.273(4)(a), and a higher temporary disability rate were at stake. (See Order issued pursuant to ORS 656.307; OAR 438-60-180(12).) Accordingly, claimant was not procedurally barred from litigating her request for hearing asserting a "new injury" claim.

Turning to the attorney fee matter, claimant's attorney requested a hearing to challenge both the aggravation and "new injury" denials. Thereafter, an ORS 656.307 order issued. An assessed fee may be awarded for services rendered prior to the issuance of a "307 order." Mark F. Giles, 41 Van Natta 245 (1989). Here, we conclude that the Referee's award of a $300 assessed fee was appropriate.

ORDER

The Referee's order, dated April 28, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its attorney representing Medford School District No. 549C, not to exceed $422.

JAMES D. TATE, Claimant
Charles Maier, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 86-18044
December 27, 1989
Order on Reconsideration

The SAIF Corporation has requested reconsideration of that portion of our December 7, 1989, Order on Review that, inter alia, affirmed the Referee's award of an assessed attorney fee for its unreasonable late acceptance of claimant's low back condition. Specifically, SAIF cites to Ellis v. McCall Insulation, 308 Or 74 (1989) and Lloyd L. Cripe, 41 Van Natta 1774 (1989), and points out that these cases issued "subsequent to the briefing in this case."

We decline to address the merits of whether the Referee's award of an assessed fee was proper under either Ellis or Lloyd L. Cripe. We do so on procedural grounds. That is, SAIF confined its argument on Board review to the issue of the assessment of a penalty. Absent from its brief, is any argument or contention that the Referee erred in awarding an assessed fee. Moreover, the Ellis decision issued several months prior to our December 7, 1989, order. Lloyd L. Cripe followed the Court's decision in Ellis. SAIF did not submit any supplemental argument to the Board after Ellis, while this case was pending review.

Under such circumstances, we decline to entertain an issue that was raised in the first instance on reconsideration after the issuance of our December 7, 1989, order.

Accordingly, our December 7, 1989, order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 7, 1989, order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

MICHAEL P. DILWORTH, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
David Smith (SAIF), Defense Attorney

WCB 87-11891 & 87-08866
December 28, 1989
Order on Review

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of those portions of Referee Smith's order that: (1) set aside its "backup" denial of claimant's low back condition; and (2) upheld Western Employers' Insurance's "de facto" denial of the same condition. Claimant cross-requests review to "protect [his] rights [as] to which of the [two] carriers should be responsible for [ ]his accepted . . . claim."

FINDINGS OF FACT

The Board adopts those portions of the order labelled Stipulation and Facts. We make the following additional findings: The previous Opinion and Order setting aside SAIF's denial of the claim for injury on July 10, 1985 is final.

Western does not accept liability for payment of the July 10, 1987 claim.

CONCLUSIONS OF LAW AND OPINION

We have construed D. Maintenance Company v. Mischke, 84 Or App 218, rev den 303 Or 459 (1987), to permit a "backup" denial on the basis of lack of coverage only when another insurer has agreed in a guaranty contract to cover claims accepted by the denying insurer. Beverly A. Bond, 41 Van Natta 975 (1989). In this case, Western did not enter into a guaranty contract accepting responsibility for coverage of claims previously accepted by SAIF. Moreover, Western specifically refused to be responsible in this case. Therefore, the "backup" denial is invalid under Bond.

In addition, although under certain specific circumstances "backup" denials can be validly issued, an insurer may not issue a "backup" denial of a claim assigned to it by final order of a referee, board or court. Knapp v. Weyehaeuser Company,

93 Or App 670 (1988). Here, since SAIF was required to accept this claim by the Opinion and Order of the earlier Referee, its subsequent "backup" denial is invalid.

ORDER

The Referee's order, dated January 19, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $500, to be paid by the SAIF Corporation. The Board approves a client-paid fee, payable from Western Employers' Insurance to its attorney, not to exceed $727.50.

SCOTT J. ELLINGSON, Claimant	WCB 87-12933
Sellers & Jacobs, Claimant's Attorneys	December 28, 1989
Cooney, Moscato, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Neal's order that: (1) upheld the self-insured employer's partial denial relating to a congenital anomaly in his low back; and (2) rejected his request for penalties and attorney fees on the theory that the denial was unreasonable. The issues on review are compensability and penalties and attorney's fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following additions. Claimant filed a claim for a "back strain" on August 19, 1985. The employer accepted claimant's claim on August 27, 1985. On June 29, 1987, a partial denial was issued relating to a congenital anomaly in claimant's low back. A Determination Order closing claimant's claim was issued just prior to the hearing. Claimant's compensable low back injury did not worsen or render symptomatic the congenital anomaly in his low back.

OPINION AND CONCLUSIONS

The Board adopts the Referee's opinion with the following supplementation.

Claimant argues that the employer's partial denial was invalid under Roller v. Weyerhaeuser Co., 67 Or 583, amplified, 68 Or App 743, rev den 297 Or 601 (1984). Claimant's accepted claim was closed by Determination Order prior to the hearing, although a copy of that document was not in the record. The Referee found the conditions to be separable and thus upheld the employer's partial denial as procedurally valid.

Even assuming, that the partial denial was improper under Roller before claim closure, it was proper for the Referee to address the merits of the denial after claim closure. See Roller v. Weyerhaeuser Co., supra, 67 Or App at 587; Chaffee v. Nolt, 94 Or App 83 (1988). The purpose of the Roller decision is to prevent an insurer/employer from bypassing a determination of the injured worker's permanent disability by issuing a partial denial of an inseparable condition. In this matter, the employer accepted a claim for a "back strain". The congenital anomaly was never a part of the accepted claim and was not diagnosed until April 1987 after his treating doctor indicated the treatment for

the strain would be palliative. Georgia-Pacific Corp v. Piwowar, 305 Or 494 (1988); Johnson v. Spectra Physics, 303 Or 49 (1987). There is no claim nor was there any evidence that any medical treatment was not paid nor that any treatment was not provided. However, as in the Roller, the partial denial in the instant matter was not a proper closure order, even though the employer treated the claim as a medical only claim.

The medical reports of Dr Sirounian and Dr. Utterback indicate that claimant's congenital anomaly was not worsened by the industrial injury of August 1985. The treating doctor does not specifically address this issue of a worsening of the preexisting condition, although he alludes to claimant being asymptomatic prior to the injury. The Referee found no worsening and we agree .

ORDER

The Referee's order dated January 8, 1988 is affirmed. A client-paid fee of up to $776 is approved.

JAMES C. INGRAM, Claimant
Roll, et al., Claimant's Attorneys
Sharon Schooley (SAIF), Defense Attorney

WCB 86-17820
December 28, 1989
Corrected Order on Review

It has come to our attention that our prior Order on Review, which was mailed on December 27, 1989, was undated. In order to correct this oversight, we issue the following corrected order.

Claimant requests review of Referee Schultz's order which declined to assess penalties and related attorney fees for the SAIF Corporation's late payment of penalties and related attorney fees. On review, the sole issue is penalties and related attorney fees.

FINDINGS OF FACT

At hearing, the parties stipulated that the penalties and attorney fee ordered by a prior Referee's October 29, 1986 order, which was affirmed by a July 31, 1987 Board order, were received two days late. The attorney fee amounted to $2,250 and the penalties were $534.40.

CONCLUSIONS OF LAW

On reconsideration, the Referee granted SAIF's Motion to Dismiss on the basis that penalties and attorney fees are not "compensation." We do not agree that dismissal was proper; however, we do agree that there is no basis for an additional penalty or related attorney fee.

ORS 656.283(1) gives any party or the director the right to request a hearing on any question concerning a claim. Issues regarding the processing of claims in accordance with Referee or Board orders are questions concerning a claim. Claimant raised the issue of SAIF's failure to comply with a Board order and was entitled to have that issue adjudicated, regardless of the merits of the request for hearing. The Referee had jurisdiction and dismissal on a jurisdictional basis was not proper.

Penalties and related attorney fees are controlled by ORS 656.262(10) and 656.382(1). Both provisions are invoked where there is unreasonable behavior by a carrier in delaying or refusing to pay compensation. However, penalties and related attorney fees are not compensation within the meaning of these two provisions. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1987); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Accordingly, there is no basis to assess an additional penalty and related attorney fee in the present case.

ORDER

The Referee's order dated May 24, 1988, as reconsidered on May 25, 1988, is affirmed.

JOSEPH SWEET, Claimant
Reynolds & Smith, Claimant's Attorneys
Kilpatrick & Pope, Defense Attorneys

WCB 87-03179
December 28, 1989
Order on Reconsideration

By Order on Review dated November 2, 1989, as reconsidered November 29, 1989, the Board remanded claimant's leg injury claim "to the employer for processing according to law." It has since come to our attention that the employer had previously requested a hearing to contest a proposed order of the Director (of the Department of Insurance and Finance) declaring him a noncomplying employer (WCB Case No. 88-10527). See ORS 656.052(2), 656.740(1). Although that hearing request is not a part of this record, it is present in our Hearings Division's files. Therefore, we take administrative notice of that hearing request inasmuch as it presents a question concerning the complying status of the employer. See Susan K. Teeters, 40 Van Natta 1115, 1118 (1988)(The Board may take administrative notice of a hearing request.).

There is no authority in ORS Chapter 656 that permits a noncomplying employer to process claims for occupational injuries or diseases. Rather, the SAIF Corporation is the exclusive processor of claims filed with a noncomplying employer. See ORS 656.054. Moreover, ORS 656.054 is the sole statutory authority for referring a claim with a noncomplying employer. See James L. Guyton, 41 Van Natta 1277, 1279 (1989). That statute requires the Director to refer such a claim to SAIF. Id. There is no statutory authority that permits the Board to refer the claim directly to SAIF.

In light of the statutory scheme above, the Board's remand of this claim to the employer for processing was improper. Because the employer's complying status is in dispute, claimant's claim shall be referred to the Director, Workers' Compensation Division, Investigation Section. The Director can then refer the claim to either SAIF for processing under ORS 656.054 if the employer is noncomplying, or the appropriate carrier for regular processing if the employer is complying.

Accordingly, our prior orders are withdrawn. On reconsideration, as amended herein, we adhere to and republish our prior orders in their entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

JOSE L. CERVANTES, Claimant
Brian R. Whitehead, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-10337
December 29, 1989
Order on Review (Remanding)

Reviewed by Board Members Gerner and Myers.

The insurer requests review of those portions of Referee Huff's order, as amended by the Order on Reconsideration issued by Referee Seymour, which: (1) set aside the insurer's "back-up" denial of claimant's industrial injury claim for a low back condition; (2) upheld the insurer's partial denial of claimant's current low back condition; and (3) assessed a penalty and attorney fee for an unreasonable denial. The insurer also moves for remand. On review the issues are the propriety of the "back-up" denial, compensability of claimant's current low back condition, penalty and fees, and remand. We remand.

Claimant was allegedly injured on June 2, 1986 when a tree fell on him. Claimant filed a claim on June 23, 1986. The insurer accepted the claim on July 3, 1986. The insurer denied the claim ab initio on July 13, 1987. The insurer partially denied claimant's current low back condition on October 1, 1987.

Claimant requested a hearing to protest the denials. Referee Huff presided over the hearing which occurred on November 12, 1987. The insurer's case rested, in large part, on attacking claimant's credibility. The Referee noted that while there were some inconsistencies in claimant's version of the injury, the basic story was consistent. The insurer also sought to prove that claimant had been involved in a bar fight on August 9, 1986 in which the participant had complained to police that they had injured his back. Claimant denied under oath that he had participated in the bar fight. The Referee concluded that claimant had not participated in the bar fight. He also concluded that even if claimant had participated in the bar fight, that would not be material to determining whether the original acceptance had been procured by fraud, misrepresentation or other illegal activity. Finally, the Referee found, based on claimant's demeanor, that he was a credible witness.

The Referee set aside the "back-up" denial. He also set aside the partial denial of claimant's current condition. He reasoned that claimant's credible testimony established the compensability of claimant's current low back condition.

The insurer requested reconsideration; however, the Referee had left the employ of this agency. The case was assigned to Referee Seymour on reconsideration. Referee Seymour amended the Opinion and Order, in part, but declined to address the merits of the issues before us on review.

The insurer then requested review. In a later hearing, before Referee Quillinan, claimant admitted that he lied about the bar fight in the hearing before Referee Huff. The insurer has now moved to remand the case to consider evidence about the bar fight and claimant's credibility.

We may remand to the Hearings Division upon a finding that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). We so find.

We agree with and adopt the following statement from the insurer's brief:

"Due diligence is not really a consideration in this situation. It is untenable as a matter of policy or equity to suggest employer should have adduced enough evidence at the first hearing to force claimant to admit he lied."

Claimant's credibility was a central consideration in the Referee's conclusions, particularly in regard to the partial denial. In view of claimant's admission in the later hearing that he lied before Referee Huff, we conclude that the record before Referee Huff was incompletely developed.

Accordingly, the Referee's order, dated February 22, 1988, as reconsidered on March 8, 1988, is vacated. This matter is hereby remanded to the Presiding Referee to assign to a Referee to consider evidence concerning the bar fight and, therefore, claimant's credibility and to decide if and how this evidence changes the disposition of all issues which were raised before Referee Huff. The Referee may conduct the proceedings in whatever manner satisfies substantial justice.

The Board approves a client-paid fee not to exceed $2,150.50, payable from the insurer to its counsel.

IT IS SO ORDERED.

LESTER K. COMSTOCK, Claimant	WCB 87-06359, 87-06358 & 86-07985
Peter O. Hansen, Claimant's Attorney	December 29, 1989
Cummins, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Blevins' order that: (1) declined to find a valid aggravation claim; (2) declined to award associated interim compensation; (3) upheld the self-insured employer's aggravation denial of his allegedly worsened low back condition; (4) upheld the employer's compensability denial of his psychiatric condition; and (5) upheld the employer's denial of his bilateral wrist condition. In addition, claimant requests that the Board assess a penalty and fee for the employer's allegedly unreasonable denial of pain center treatment. The employer cross-requests review of that portion of the Referee's order that awarded interim compensation from December 1, 1986, through April 15, 1987, for an alleged new injury to claimant's low back. We reverse in part, modify in part and affirm in part.

ISSUES

The issues are:

1. Whether claimant filed a valid aggravation claim for his allegedly worsened low back condition.

2. Assuming a valid aggravation claim was filed, whether the employer had a duty to pay interim compensation.

3. Whether claimant sustained an aggravation of his compensable low back condition.

4. Whether claimant has a compensable psychiatric condition.

5. Whether claimant has a compensable bilateral wrist condition.

6. Whether the employer issued an unreasonable denial of pain center treatment.

7. Whether claimant is entitled to interim compensation from December 1, 1986, through April 15, 1987.

FINDINGS OF FACT

Claimant compensably injured his low back on October 23, 1980, while working as a laborer in the employer's sawmill. As a result, he suffered a strain and was treated conservatively by Dr. Albertson, M.D. In January, 1982, he was examined by Dr. Toon, M.D., for complaints of bilateral hand/forearm numbness. A Determination Order closed his claim in February, 1982, with no award of permanent disability.

Thereafter, claimant began to treat with Dr. Bert, an orthopedist. Myelogram results were normal, and Bert declared claimant medically stationary effective March 27, 1982. A stipulation of May 11, 1982, granted claimant 10 percent unscheduled permanent disability for his low back condition.

Claimant returned to Dr. Bert in June, 1982, with complaints about his hands. Bert found no objective pathology and released him to begin work as a security guard for a new employer. On January 10, 1983, while performing his guard duties, claimant stepped on some rotten lumber and fell through a floor, sustaining injuries to his left leg and hip. The next day, he filed an injury claim with his new employer's insurer, the SAIF Corporation, who is not a party in this proceeding. SAIF accepted the claim as a nondisabling injury. That same day, he was examined by Dr. Keizer, M.D., with whom he had been treating since October, 1982. In a letter to the employer, dated January 24, 1983, Keizer stated that he was rescinding Bert's work release and that claimant was unable to work. As a result of that injury, claimant began to walk with a limp, which, in turn, worsened his compensable 1980 low back injury.

Shortly after the January, 1983, injury, claimant was examined by Dr. Holmes, a psychiatrist. Holmes concluded that claimant was suffering from a psychiatric condition. In May, 1983, Dr. Keizer released claimant to return to work as a laborer at the sawmill. After working at the mill for only two days, claimant quit due to increased low back pain. On June 6, 1983, he was reexamined by Keizer.

In March, 1984, claimant was seen by Dr. Hoogeveen, M.D., for complaints concerning his left shoulder. Later, in September, 1984, he returned to Hoogeveen with complaints of episodical numbness in both hands. Hoogeveen prescribed wrist braces.

Claimant was reexamined by Dr. Keizer in June, 1985. In a report, dated June 27, 1985, Keizer opined that claimant was 30 percent disabled. Based on that report, claimant's attorney requested the insurer to reopen the 1980 claim. On October 28, 1985, the employer informed claimant that although it had received his aggravation claim, it was deferring action pending further information.

In March, 1986, claimant was examined by a panel of physicians, including Dr. Voiss, a psychiatrist.

Claimant filed his first Request for Hearing in June, 1986, seeking penalties and attorney fees for the employer's allegedly unreasonable refusal to process his aggravation claim. In August, 1986, claimant began treating with Dr. Mang, a chiropractor. Mang opined that on January 10, 1983, and May 31, 1983, claimant had suffered an aggravation of his 1980 injury.

The employer issued a formal denial of an aggravation, current medical treatment, and a psychiatric condition, on November 10, 1986.

On November 17, 1986, claimant completed two "801" industrial claim forms: one for bilateral carpal tunnel syndrome, allegedly due to his work activities at the sawmill; and, the second, for an alleged "new injury" to his low back on May 31, 1983. The employer formally denied each claim by way of a denial, dated April 15, 1987.

Dr. Nathan, a hand specialist, examined claimant prior to the hearing.

ULTIMATE FINDINGS OF FACT

Dr. Keizer's report of January 24, 1983, indicated that claimant was in need of further medical treatment and that he was no longer able to work, due to a reinjury of his low back on January 10, 1983.

Save for the two days in which claimant returned to work for the employer on May 31 and June 1, 1983, he has remained out of work since January 10, 1983.

Claimant's underlying low back condition, which resulted from the compensable October, 1980, injury, was a material contributing cause of his worsened condition on January 10, 1983.

The compensable low back injury of October, 1980, was not a material contributing cause of claimant's alleged psychiatric condition.

Claimant work activities at the sawmill were not the major contributing cause of either the onset or worsening of his bilateral carpal tunnel syndrome.

Claimant did not sustain a "new injury" or a compensable aggravation when he returned to work at the sawmill on May 31, 1983 and June 1, 1983.

Claimant did not raise the issue of the employer's alleged unreasonable denial of pain center treatment, until after the record below had been closed.

The employer did not receive notice or knowledge of either of claimant's November 17, 1986, new injury claims, until December 30, 1986.

CONCLUSIONS OF LAW

Aggravation Claim

The Referee found that claimant had not made a valid claim for aggravation. We disagree.

ORS 656.273(3) provides: "A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." On January 24, 1983, Dr. Keizer wrote the employer a letter informing it that claimant was no longer able to work due to an injury of January 10, 1983. (Ex. 43). Keizer further indicated that, ultimately, muscle strengthening exercises would enable claimant to return to work. The letter is date stamped "received" by the employer, on April 7, 1983.

In our view, Dr. Keizer's letter of January 24, 1983, was an aggravation claim. It plainly informed the employer that claimant needed further treatment for his back due to an altered gait caused by the left leg/hip injury of January 10, 1983, and that, as a result, he was no longer able to work. Krajacic v. Blazing Orchards, 84 Or App 127 (1987) (Employer must be put on notice, as here, that further medical services are for more than merely continuing conditions).

Interim Compensation vis-a-vis Aggravation Claim

In aggravation cases an employer must begin the payment of interim compensation once it has "notice or knowledge of medically verified inability to work resulting from the worsened condition." ORS 656.273(6); see ORS 656.262(4). Here, as we found above, Dr. Keizer informed the employer that claimant was no longer able to work due to the injury of January 10, 1983, and that he was rescinding Dr. Bert's work release.

Under such circumstances, we conclude that the employer had notice or knowledge of a medically verified inability to work due to a worsened condition, by, at least, April 7, 1983. Because we conclude herein that claimant suffered a compensable aggravation, temporary disability should be paid from January 10, 1983, the date of claimant's disability, Spivey v. SAIF, 79 Or App 568 (1986) and Kosanke v. SAIF, 41 Or App 17 (1979), through November 10, 1986, the date of its denial, less time worked on May 31 and June 1, 1983. Bono v. SAIF, 298 Or 405 (1984).

Aggravation

For every claim of aggravation of an unscheduled condition, the claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity. In those cases in which the last award or arrangement of unscheduled permanent partial disability compensation anticipated future periods of increased symptoms or exacerbation of the physical condition, accompanied by a diminished earning capacity, the claimant must also prove that his earning capacity was diminished longer or in greater degree than was anticipated or that his earning capacity was diminished to the extent of total disability, and resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (December 8, 1989).

Here, the last arrangement of compensation was the stipulation of May 11, 1982, which awarded claimant 10 percent unscheduled permanent disability for his low back. The stipulation does not state that the parties contemplated future symptomatic flare-ups. Prior to the stipulation, claimant had been released for "light medium work" by Dr. Bert. The employer, however, was unable to reemploy him. One week after the stipulation was entered, Bert opined that although claimant was medically stationary, he may need intermittent physical therapy to allow him to continue working. On July 1, 1982, Bert released claimant to perform security guard work, without limitations. A few months later, claimant began treating with Dr. Keizer.

On January 10, 1983, claimant injured his left leg and hip, while working as a security guard for SAIF's insured. He returned to Dr. Keizer, the next day. On January 21, 1983, Keizer noted:

> "The [claimant] strained his left ankle and left knee and has been forced to limp on this some and has not been able to take his exercises since the day of the accident[,] which was 1-13-83 [sic]. The [employer is] being notified of this problem and also that he had been improving in his leg strength and back strength by the exercises up until this point. The patient comes [in with] complain[ts] of soreness <u>which [ha]s aggravated his back[,] but I believe it is more from the effect of the limping</u> than it is from any possible injury * * *." The [claimant] was able to finish his shift that evening[,] but he was quite tender and sore and has been so since. He has not needed to report for duty and <u>it is very unlikely that he can do so</u>. (Emphasis added).

A few days later, Dr. Keizer further reported that claimant was unable to work and that Dr. Bert's work release was "present[ly] rescind[ed]." Likewise, in April, 1983, Dr. Holmes examined claimant and reported that the injury of January 10, 1983, had "slightly exacerbated [claimant's] back."

After review of this evidence, we are persuaded that claimant suffered an increase in symptoms resulting in the diminishment of his earning capacity. In reaching this conclusion, we rely upon the following findings. As a result of the January 10, 1983, reinjury, claimant began to limp, which worsened his preexisting low back condition to the point that he became less able to work. As the treating physician who observed claimant both before and after January 10, 1983, we are persuaded by Dr. Keizer's well-reasoned opinion. <u>Kienow's Food Stores v. Lyster</u>, 79 Or App 416 (1986); <u>Weiland v. SAIF</u>, 64 Or App 810 (1983).

In accordance with the analysis applied in <u>Lucas</u>, we turn to the question of whether the last arrangement of compensation, the May 11, 1982 stipulation, anticipated future symptomatic or pathological exacerbations, accompanied by a diminished earning capacity. We conclude that it did not. As previously noted, after conducting our review of the medical and lay evidence, we

find that neither the stipulation nor the medical evidence available at that time contemplated future symptomatic flare-ups.

Because no symptomatic flare-ups were contemplated by the prior arrangement of compensation, any flare-up resulting in diminished earning capacity is at least a temporary worsening. Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988). Accordingly, claimant has established a worsening of his low back condition since the last arrangement of compensation.

Psychiatric Condition

The Board adopts that portion of the Referee's opinion concerning the compensability of claimant's psychiatric condition.

Carpal Tunnel Syndrome

The Board adopts that portion of the Referee's opinion concerning the compensability of claimant's bilateral wrist condition.

Pain Center Treatment

Claimant did not raise the issue of an unreasonable denial of pain center treatment, until after the record below had been closed. On review, we do not entertain issues that, like this one, have not been properly raised below. Mavis v. SAIF, 45 Or App 1059 (1980); Randy D. Johnson, 39 Van Natta 463 (1987). We, therefore, do not consider this issue.

Interim Compensation vis-a-vis New Injury Claims

The Referee awarded claimant interim compensation from December 1, 1986, for his new injury claims signed on November 17, 1986. We modify.

The employer's date stamp shows that it received claimant's new injury claims on December 30, 1986. The record, so far as we are aware, does not reveal any evidence to indicate that the employer received notice or knowledge of those new injury claims before December 30, 1986. Accordingly, interim compensation for the new injury claims is payable beginning December 30, 1986.

ORDER

The Referee's order, dated March 30, 1988, is reversed in part, modified in part, and affirmed in part. That portion of the order that upheld the employer's November 10, 1986, aggravation denial and declined to award interim compensation, is reversed. The denial is set aside and the employer shall pay benefits and process the claim according to law. Claimant is entitled to interim compensation benefits from January 10, 1983, through November 10, 1986, less time worked on May 1 and June 1, 1983. That portion of the Referee's order that ordered the payment of interim compensation from December 1, 1986, to April 15, 1987, is modified. Those payments should be payable from December 30, 1986 to April 15, 1987. The Referee's award of a 25 percent penalty, shall be reduced accordingly. Claimant's attorney is awarded an approved fee for the increased compensation awarded by this order, provided that the total of fees awarded by the Referee and the

Board do not exceed $3,800. The Board approves a client-paid fee, payable from the self-insured employer to its attorney, not to exceed $2,342. All remaining portions of the Referee's order are affirmed. For services at hearing and on Board review concerning the aggravation issue, claimant's attorney is awarded $2,000, to be paid by the self-insured employer.

WALTER F. DREWS, Claimant	WCB 89-11171
Cash R. Perrine, Claimant's Attorney	December 29, 1989
Roberts, et al., Defense Attorneys	Order Denying Motion to Dismiss

The insurer has moved the Board for an order dismissing claimant's request for review of a Referee's November 7, 1989 order, which dismissed claimant's hearing request for lack of jurisdiction. We conclude that we have jurisdiction to consider claimant's request for review and deny the motion to dismiss.

FINDINGS OF FACT

In June 1989 claimant submitted a hearing request contending that the insurer had failed to comply with a recent Court of Appeals decision and pay additional temporary total disability compensation. Claimant also sought penalties and attorney fees for alleged unreasonable claims processing. Thereafter, the insurer moved for dismissal of the hearing request, contending that the Referee lacked jurisdiction to consider the issues raised by claimant's request.

On November 7, 1989, the Referee issued an Opinion and Order. Finding that he was without authority to address the issues raised by claimant's hearing request, the Referee granted the insurer's motion to dismiss.

On November 16, 1989, claimant mailed a request for Board review of the Referee's order to the Board. The request included a certificate of personal service by mail upon the employer and its insurer.

CONCLUSIONS OF LAW

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

Here, the 30th day after the Referee's November 7, 1989 order was December 7, 1989. Claimant's request for review was mailed to the Board and copies were mailed to the other parties to the proceeding on November 16, 1989. Inasmuch as the aforementioned submissions were made within 30 days of the issuance of the Referee's November 7, 1989 order, we have jurisdiction to consider this case. See ORS 656.289(3); 656.295(2).

The insurer seeks dismissal of claimant's request, asserting that the appeal "has absolutely no merit." The insurer provides no authority for its assertion that an otherwise timely request for Board review should be dismissed for an alleged lack of

merit. Finding no authority for such a proposition, we disagree with the insurer's contention.

Because claimant timely requested Board review, the Referee's order has not become final. ORS 656.289(3). 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 issues of whether the Referee had jurisdiction to consider the merits of claimant's hearing request, as well as the relief sought therein, remain viable.

Accordingly, the motion to dismiss is denied. As a result of this order, it will be necessary to revise the briefing schedule. The insurer's respondent's brief shall be due 14 days from the date of this order. Claimant's reply brief shall be due 7 days from the date of mailing of the insurer's brief. Thereafter, the case will be docketed for review.

IT IS SO ORDERED.

PHYLLIS I. DUPAPE, Claimant	WCB 87-18387
Pozzi, et al., Claimant's Attorneys	December 29, 1989
Meyers & Radler, Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of Referee Heitkemper's order which set aside its denial of claimant's medical care provided by a particular out-of-state chiropractor. The issue on review is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as set forth in the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the employer's denial of medical care by an out-of-state chiropractor. We agree that the denial should be set aside, but we base our conclusion upon the following reasoning.

The Board has found that an injured worker has the initial right to select an out-of-state attending physician and that choice of attending physician is subject to an insurer's right of veto. Monty R. Jones, 41 Van Natta 1288 (1989) citing, Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985); Day v. S & S Pizza Co., 77 Or App 711 (1986).

We construe Reynaga and Day to stand for the proposition that the employer has a limited right to veto out-of-state care and a basis must be demonstrated in the exercise of such veto. Under the Reynaga and Day holdings, the only adequate basis for a veto would appear to be circumstances under which the out-of-state doctor is unlikely to comply with reporting requirements. Reynaga, 300 Or at 258, Day, 77 Or App at 716.

In the present case, the employer has not shown that claimant's out-of-state chiropractor would be unlikely to cooperate with reporting requirements. We therefore agree with the Referee's conclusion that the employer's denial of medical care should be set aside.

Claimant is entitled to a carrier-paid fee for services on review. ORS 656.382(2). However, because no statement of services has been received, no fee can be awarded. OAR 438-15-005(2); OAR 438-15-010(5).

ORDER

The Referee's order, dated August 2, 1988, is affirmed. A client-paid fee, payable from the employer to its counsel, not to exceed $328, is approved.

BRUCE H. GINGERY, Claimant	WCB 88-08132
Malagon, et al., Claimant's Attorneys	December 29, 1989
Employers Defense Counsel, Defense Attorney	Order on Review

Reviewed by Board Members Gerner and Myers.

The insurer requests review of those portions of Referee Quillinan's order which: (1) directed it to pay to claimant $1,492.56 allegedly due under the order of a different Referee; (2) directed it to pay a 25 percent penalty for resistance to the payment of that amount; (3) directed it to pay to claimant $211.81 also allegedly due under the order of a different Referee; and (4) directed the insurer to pay a 25 percent penalty for resistance to the payment of that amount. Claimant cross-requests review of that portion of the Referee's order which authorized the insurer to offset the $1,492.56 against permanent disability. We affirm in part and reverse in part.

ISSUES

The first issue is whether the Referee was correct to require the insurer to pay the $1,492.56. The insurer contends that claimant is barred from raising this issue because it is res judicata. The insurer further contends that it should not be subject to a penalty and associated attorney fee for failure to pay this amount because Referee Brazeau had this issue before him and did not require the insurer to pay this amount.

The insurer also contends that it had no obligation to pay $211.81 under Referee Brazeau's order because there were no amounts due upon which Referee Brazeau could have based a penalty. The insurer further argues that there can be no penalty based upon this amount because there was no compensation resisted.

Claimant contends that the Referee erred in authorizing an offset because the insurer did not raise this issue.

FINDINGS OF FACT

Claimant has a compensable injury dating from 1983. In a hearing before Referee McCullough on March 5, 1986 one issue was claimant's correct time loss rate. By Opinion and Order of March 17, 1987, Referee McCullough concluded that the insurer had incorrectly calculated the time loss rate. He ordered the insurer to recalculate the time loss rate. He also granted an increased award for unscheduled disability. On April 13, 1987, the insurer paid claimant $1,129.66 for underpaid time loss for the period May 3, 1983 through January 5, 1986.

The insurer recalculated the time loss rate and discovered that while the rate it had paid claimant for time loss was

incorrectly low, it had actually overpaid claimant $1,492.56. It unilaterally offset this amount against claimant's permanent partial disability benefits.

A second hearing occurred on January 26, 1988 before Referee Brazeau. In an Opinion and Order dated February 10, 1988, Referee Brazeau concluded that the insurer had unilaterally imposed the offset. He ordered the insurer to pay a 25 percent penalty. By an Order on Reconsideration, he also ordered the insurer to pay a 25 percent penalty for the late payment of time loss due under Referee McCullough's order.

The insurer paid the 25 percent penalty based on the $1,492.56. It did not repay the $1,492.56 to claimant. It did not pay the penalty based on the late payment of time loss due under Referee McCullough's order. The insurer has never requested authorization to offset the $1,492.56.

CONCLUSIONS AND OPINION

Referee Quillinan concluded that the $1,492.56 continued to be due under Referee McCullough's order. Consequently, she ordered the insurer to repay that amount to claimant and ordered an additional penalty for the continued failure to repay it; however, she then authorized the insurer to offset that amount. We agree that this amount continued to be due under Referee McCullough's order and that the continued failure to repay it after Referee Brazeau's order was a further resistance to the payment of compensation. We do not agree, however, with the Referee's authorization of the offset.

Referee McCullough ordered the insurer to pay a significant amount of permanent partial disability. The insurer has never paid the full amount of that permanent partial disability award because it unilaterally offset $1,492.56 of it. Before Referee Quillinan's order, no one authorized to approve an offset had done so. Accordingly, Referee Brazeau did not need to order the insurer to repay that amount; the insurer continued to be obligated to pay it under Referee McCullough's order. Thus, the fact that Referee Brazeau did not specifically order this amount paid, does not mean that the issue of the insurer's obligation to pay it was decided by Referee Brazeau. It is not res judicata.

The insurer's failure to repay this amount after Referee Brazeau's order had found the offset unreasonable was a further resistance to the payment of compensation which the insurer should have paid. Accordingly, we affirm those portions of Referee Quillinan's order which required the insurer to repay the $1,492.56 and which assessed a penalty.

We disagree with the Referee's authorization of an offset. The insurer has never raised this as an issue. Accordingly, the Referee should not have authorized the offset on her own motion.

We also affirm those portions of Referee Quillinan's order which required the insurer to pay the $211.81 penalty due under Referee Brazeau's order. Referee Brazeau's order was not appealed; therefore, whether or not the insurer should have paid the time loss under Referee McCullough's order is irrelevant. Referee Brazeau ordered the insurer to pay this penalty and it should have done so.

We reverse those portions of Referee Quillinan's order which imposed a penalty based on the penalty. A penalty is not compensation and, therefore, it is not an amount due upon which a penalty can be based.

The Referee did not apportion the assessed attorney fee among the various issues. On de novo review, we conclude that the $800 attorney fee she assessed for all issues is an appropriate fee for the issues upon which claimant continues to prevail.

ORDER

The Referee's order, dated July 15,1988, is affirmed in part and reversed in part. Those portions of the Referee's order which ordered the insurer to pay a penalty based on the $211.81 penalty are reversed. Those portions of the Referee's order which authorized an offset are reversed. The balance of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $700, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $720.

GARY W. MALSBERGER, Claimant
Brian R. Whitehead, Claimant's Attorney
Roberts, et al., Defense Attorneys
Stafford J. Hazelett, Defense Attorney

WCB 87-18954 & 88-01495
December 29, 1989
Order on Review

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Seymour's order which: (1) upheld the Kemper Insurance Company's ("Kemper's") denial of claimant's aggravation claim for a low back injury; (2) upheld Liberty Northwest Insurance Corporation's ("Liberty Northwest's") denial of claimant's "new injury" claim for the same condition; and (3) declined to assess penalties or attorney fees for an alleged unreasonable denial by Kemper. On review, the issues are compensability, responsibility, and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

In August 1985, claimant sustained a low back injury while working as a construction laborer for Kemper's insured. The claim was closed by a May 1986 Determination Order that awarded claimant 15 percent unscheduled permanent disability. A September 1986 Stipulation granted claimant an additional 12.5 percent unscheduled permanent disability.

In December 1986, claimant filed an aggravation claim with Kemper. The claim was denied and a request for hearing on that aggravation claim was settled by a disputed claim settlement of August 1987.

In October 1987, claimant began working as a manager trainee for Liberty Northwest's insured, a fast-food restaurant. His bending and turning activities at Liberty Northwest's insured caused him to experience increased symptoms in his low back. On November 6, 1987, his treating chiropractor released him from work due to the increased symptoms.

On November 17, 1987, Kemper denied responsibility for claimant's aggravation claim. On December 4, 1987, a new injury

claim was filed with Liberty Northwest, which it timely denied on the basis of compensability and responsibility. At hearing, Kemper extended its denial to include compensability as well as responsibility.

FINDINGS OF ULTIMATE FACT

Prior to the industrial injury, claimant was able to do heavy work. Following the industrial injury, claimant could perform only medium work.

At the time of the September 1986 Stipulation, the parties contemplated that claimant would have future symptomatic flare-ups. (Exs. 35, 43, 49B).

In November 1987, claimant's compensable low back condition symptomatically worsened. As a result of this worsening, claimant was disabled from working in excess of 14 days.

Claimant's work activities at Liberty Northwest's insured did not result in a worsening of his underlying low back condition.

Kemper's denial of responsibility was reasonable.

CONCLUSIONS OF LAW

The Referee concluded that claimant had not established a loss of earning capacity since the last arrangement of compensation and therefore upheld both insurer's denials. We disagree.

COMPENSABILITY

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987).

A. Aggravation-Kemper's insured

For every claim of aggravation of an unscheduled condition, the claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity. In those cases in which the last award or arrangement of unscheduled permanent partial disability compensation anticipated future periods of increased symptoms or exacerbation of the physical condition, accompanied by a diminished earning capacity, the claimant must also prove that his earning capacity was diminished longer or in greater degree than was anticipated or that his earning capacity was diminished to the extent of total disability, and resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (December 8, 1989).

Drs. Whitmire and Butler, claimant's treating chiropractors, reported that claimant had sustained a severe aggravation of his compensable condition in November 1987. Dr. Butler noted that claimant had been released to modified work prior to that time, but that the work at Liberty Northwest's insured had caused a symptomatic increase necessitating claimant's release from work.

Dr Poulson opined that claimant had a chronic condition which would present problems depending on claimant's activities. He opined in February 1988, that claimant's condition was stationary. In March 1988, Independent Chiropractic Consultants opined that the November 1987 worsening was an aggravation without a worsening of the underlying condition.

The uncontradicted medical evidence is that claimant sustained a symptomatic exacerbation of his compensable low back condition. We are further persuaded that this exacerbation resulted, at least temporarily, in a diminishment of claimant's earning capacity below the level fixed at the time of the last arrangement of compensation.

In reaching this conclusion, we note that prior to his industrial injury, claimant was able to perform heavy construction work. Following the injury, he was only able to perform work in the medium range. Claimant's last arrangement of compensation was based in large part on the fact that claimant could perform only medium work following his industrial injury. At the time of his November 1987 exacerbation, claimant was working as a management trainee for Liberty Northwest's insured. This position would be classified as light to medium work. Due to his exacerbation, claimant was totally disabled from performing such work for more than 14 days.

In accordance with the Lucas analysis, we next turn to the question of whether the last arrangement of compensation, the September 1986 stipulation, anticipated future symptomatic or pathological conditions, accompanied by a diminished earning capacity. We conclude that it did.

Claimant's last arrangement of compensation was the September 1986 Stipulation that increased his unscheduled permanent disability award to 27.5 percent. We infer that, at that time, the parties considered the existing evidence which indicated that claimant had experienced periodic symptomatic flare-ups in the past and would continue to experience such flare-ups in the future. See Gwynn v. SAIF, 91 Or App 84, 88 (1988).

Although the last arrangement of compensation anticipated that claimant would experience periodic symptomatic flare-ups accompanied by a diminished earning capacity, the record establishes that claimant's earning capacity was diminished to the extent of total disability for 14 consecutive days. Thus, claimant has proven a worsening of his low back condition since the last arrangement of compensation. Accordingly, a compensable aggravation has been established.

B. Injury--Liberty Northwest's Insured

Dr. Whitmire reported that standing and bending while working at Liberty Northwest's insured had caused an increase in claimant's symptomatology. Dr. Poulson opined that claimant's condition was chronic and would give him difficulty depending on the level of activity. He recommended that claimant be encouraged to find work that did not involve repetitive bending or lifting. There is no medical evidence to the contrary. Under such circumstances, we conclude that claimant sustained an injury at Liberty Northwest's insured which resulted in disability. See ORS 656.005(7)(a). Thus, claimant has established a compensable injury as to Liberty Northwest's insured.

RESPONSIBILITY

In successive injury cases, as here, to shift responsibility to a later employer, the later employment must independently contribute to a worsening of the worker's underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

Here, the preponderance of the medical and lay evidence establishes an independent contribution from claimant's bending and twisting activities at Liberty Northwest's insured. The medical evidence is in agreement, however, that claimant's condition in November 1987 represented merely a symptomatic flare-up and not a worsening of his underlying low back condition. This opinion was given by claimant's treating chiropractors, Dr. Poulson, and the Independent Chiropractic Consultants. Under such circumstances, we conclude that claimant's work exposure at Liberty Northwest's insured did not worsen his underlying low back condition. Accordingly, responsibility for claimant's current condition does not shift to Liberty Northwest, but remains with Kemper.

PENALTIES AND ATTORNEY FEES

Regarding claimant's contention that Kemper's denial was unreasonable, we are not persuaded. Kemper's denial was issued following claimant's release from work while working for Liberty Northwest's insured. Inasmuch as Kemper had a legitimate doubt at that time concerning its liability for claimant's condition, its denial was not unreasonable. We, therefore, agree with the Referee insofar as he declined to assess a penalty or related attorney fee.

ORDER

The Referee's order, dated May 16, 1988, is reversed in part and affirmed in part. That portion which upheld Kemper's denial of claimant's aggravation claim for a low back injury is reversed. Kemper's denial is set aside and the claim is remanded to it for processing according to law. Liberty Northwest's denial is reinstated and upheld. For services rendered at hearing and on review, concerning the compensability issue, claimant's counsel is awarded a reasonable assessed fee of $2,000, to be paid be Kemper. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,080, is approved, payable by Kemper to it's counsel.

CHESTER L. WING, Claimant	WCB 86-16580
Larry I. Voth, Claimant's Attorney	December 29, 1989
Davis & Bostwick, Defense Attorneys	Order on Review

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee Podnar's order which: (1) granted claimant permanent total disability, whereas a Determination Order had awarded 55 percent (176 degrees) unscheduled permanent disability for a low back injury; (2) set aside its denial of claimant's medical services claim for diagnostic services; and (3) assessed a penalty and related attorney fee for failure to pay for diagnostic services. On review, the issues are extent of unscheduled permanent

disability, including permanent total disability, and compensability of medical services. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back in February 1977. The injury was diagnosed as a lumbar strain in addition to preexisting degenerative arthritis. Claimant was treated conservatively and he returned to work following the injury. His condition worsened in 1980 and he was again taken off work. His claim was subsequently reopened as an aggravation by Board order. See Chester L. Wing, 34 Van Natta 718 (1982).

In mid-1981, claimant developed a depression and anxiety condition as a result of his compensable injury. Although initially denied by the insurer, claimant's psychological problem was ultimately accepted as a consequence of the 1977 compensable injury. Claimant was released from work in 1982 for psychiatric treatment. In 1984, vocational efforts began. In April 1986, claimant's treating psychiatrist, Dr. Achord, withdrew claimant from the vocational program due to a deterioration of his psychological condition.

In June 1986, Achord referred claimant to Dr. McMullan, internist, for diagnosis as claimant had experienced shortness of breath and a tightness in his chest. In September 1986, a Determination Order closed claimant's claim awarding 55 percent unscheduled permanent disability.

Claimant is 61 years old and has an 11th grade education. His employment history includes work as a welder, millwright, manufacturing supervisor, and field supervisor for a dry kiln. As a result of his compensable injury, he has permanent low back impairment in the moderate to severe range. He cannot perform activities that require repetitive bending or lifting or prolonged standing or sitting. As a result of his compensable injury, he has permanent psychological impairment in the severe range.

FINDINGS OF ULTIMATE FACT

As a result of his compensable low back injury and psychological condition, claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

Claimant's initial visit to Dr. McMullan was for diagnostic purposes. Thereafter, his visits to McMullan were for treatment purposes.

CONCLUSIONS OF LAW

Permanent Total Disability

The Referee concluded that claimant was permanently and totally disabled as a result of his compensable physical and pyschological conditions. We agree.

To establish permanent total disability, claimant must prove that he is unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(2); Wilson v. Weyerhaeuser,

30 Or App 403 (1977). In addition, he must prove that he met the statutory seek-work requirement of ORS 656.204(3), unless to do so would have been futile.

In 1983, Dr. Rusch, claimant's treating orthopedist, opined that claimant was medically stationary from a musculoskeletal standpoint and that his low back condition had resulted in permanent impairment in the moderate to severe range. At that time, however, he noted that claimant still had severe psychological problems. There is no contrary medical evidence regarding claimant's physical condition.

In conjunction with this, Dr. Achord, claimant's treating psychiatrist since 1982, opined that claimant's psychological impairment was in the severe range. He further opined that claimant's psychological depression and anxiety condition prevented claimant from being able to work or even look for work.

Dr. Parvaresh, psychiatrist, examined claimant three times, in 1982, 1985, and 1986. He opined that claimant's condition had improved since 1982 and felt that claimant was not unemployable from a psychiatric standpoint. Dr. Parvaresh concluded that claimant's psychological impairment was in the mild range and noted that claimant's lifelong feelings of inferiority and inadequacy were the cause of his rehabilitative difficulties. Dr. Turco, who examined claimant in panel with Dr. Parvaresh in 1986, concurred.

We do not find the opinions of Drs. Parvaresh and Turco persuasive. Their 1986 opinion that claimant is employable does not take into consideration the fact that claimant had been treating with Dr. Achord since 1982 and was on continuous medication during that time period. Further, their opinion relates claimant's difficulties to lifelong psychiatric problems, whereas the record is devoid of such evidence prior to the 1977 compensable injury.

We are persuaded by the opinion of Dr. Achord. He has continuously treated claimant since the onset of his psychological disability and is in a better position to offer an opinion as to claimant's disability given this protracted observation period. Weiland v. SAIF, 64 Or App 810 (1983). Given claimant's physical impairment, in conjunction with Dr. Achord's opinion as to his psychological impairment, we conclude that claimant is permanently and totally disabled as a result of his compensable physical and psychological condition.

Moreover, given Dr. Achord's opinion, we find that it would be futile for claimant to seek work. Butcher v. SAIF, 45 Or App 313 (1980).

Medical Services

The Referee concluded that all of Dr. McMullan's services were diagnostic and, therefore, compensable. We disagree.

ORS 656.245(1) extends to payment for diagnostic procedures, even when the procedures ultimately reveal that claimant's condition is not compensable. See Brooks v. D & R. Timber, 55 Or App 688 (1982). An insurer must pay for diagnostic testing, which is reasonable and necessary to determine a causal

relationship, if any, between a compensable condition and a disease process. Kenneth M. Simons, 41 Van 378, 380 (1989); Clifford D. Howerton, 38 Van Natta 1425 (1986). However, medical services under ORS 656.245(1) are limited to services for conditions "resulting from the [compensable] injury * * *."

Here, Dr. Achord referred claimant to Dr. McMullan for a diagnosis regarding claimant's symptoms of shortness of breath and tightness in his chest. After examining claimant, Dr. McMullan diagnosed probable chronic obstructive pulmonary disease with probable bronchoplasm. He then began treating claimant for this condition.

We find that the insurer was obligated to pay for claimant's initial visit to Dr. McMullan as it was for diagnostic purposes. Simons, supra. However, following the initial visit, Dr. McMullan began treating claimant for obstructive pulmonary disease. Accordingly, we conclude that the insurer was not obligated to pay for any treatment rendered by Dr. McMullan, after the initial diagnostic visit.

In reaching our conclusion we note that the parties have attempted to put compensability of these treatments at issue for the first time on Board review. However, the issue before the Referee, as framed by the parties, was whether all of Dr. McMullan's treatments were diagnostic in nature. To now decide compensability of the condition treated by Dr. McMullan would be improper and we decline to do so. See Gunther H. Jacobi, 41 Van Natta 1031 (1989).

Penalties and Attorney Fees

The Referee assessed a 25 percent penalty and $200 attorney fee against the insurer for failure to pay all of Dr. McMullan's billings. In light of our decision above, we do not find the failure to pay for Dr. McMullan's treatments, after the initial visit, unreasonable. However, failure to pay for the initial diagnostic visit was unreasonable and the insurer offers no explanation for its failure to pay. Accordingly, we modify the Referee's order and assess a 25 percent penalty based on the amount of claimant's initial visit to Dr. McMullan. We further modify claimant's counsel's fee, in regard to this issue, to $75.

ORDER

The Referee's order, dated July 6, 1988, is modified in part and affirmed in part. That portion of the order that set aside the insurer's medical services denial in its entirety is modified. The insurer's denial is set aside solely with respect to its denial of Dr. McMullan's initial doctor examination. The remaining services of McMullan, which was for treatment of the noncompensable pulmonary disease, are denied and that portion of the insurer's denial is upheld. In lieu of the Referee's assessed fee award, claimant's attorney is awarded a $200 assessed fee for services at hearing in setting aside a portion of the insurer's denial. That portion which assessed a 25 percent penalty on all of Dr. McMullan's billings and awarded a $200 related attorney fee is modified. Claimant is awarded a 25 percent penalty on the amount of Dr. McMullan's first examination and claimant's counsel is awarded an assessed fee of $75. The remainder of the order is affirmed. For services on review concerning the permanent total disability issue, claimant's counsel is awarded an assessed fee of $1,500. A client-paid fee, not to exceed 1,306.44, is approved.

CURTIS H. BEST, Claimant
Malagon, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0401M
November 1, 1989
Own Motion Order of Abatement

SAIF Corporation has requested that the Board reconsider its Ocotber 20, 1989 Own Motion Order in the aforementioned case.

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.

ROBIN MITCHELL, Claimant
Bischoff & Strooband, Claimant's Attorneys

Own Motion 84-0243M
October 26, 1989
Own Motion Order of Abatement

The insurer has requested that the Board reconsider its September 26, 1989 Own Motion Order in the aforementioned case.

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. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

RAYMOND L. POWELL, Claimant
Michael B. Dye, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-15274
November 3, 1989
Order of Abatement

The Board has received employer's Motion for Abatement and Reconsideration of our Order on Review dated October 5, 1989.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within 10 days.

IT IS SO ORDERED.

GLORIA SERNA, Claimant
Myrick, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-11974
November 2, 1989
Order of Abatement

The self-insured employer has requested reconsideration of that portion of our October 10, 1989, Order on Review, which made ultimate findings of fact inconsistent with our conclusion of law that claimant's current chiropractic treatments were not compensable.

In order to allow sufficient time to consider the motion, our prior order is abated and withdrawn. Claimant is

requested to file a response to the motion within ten days from the date of this order. Thereafter, we shall take the employer's motion under advisement.

IT IS SO ORDERED.

SARA I. SWARTWOUT, Claimant
Peter O. Hansen, Claimant's Attorney
Meyers & Radler, Defense Attorneys

Own Motion 88-0426M
October 20, 1989
Own Motion Order Abating

The self-insurered employer has requested that the Board reconsider its September 20, 1989 Own Motion Order in the aforementioned case.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The self-insured employer is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

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IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Dwight E. Fillmore, Claimant.

WEYERHAEUSER COMPANY,
Respondent,

v.

DWIGHT E. FILLMORE,
Petitioner.

(WCB 87-13806 and 87-16609; CA A49368)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 8, 1989.

Max Rae, Salem, argued the cause and filed the brief for petitioner.

Ridgway K. Foley, Jr., Dennis S. Reese and Schwabe, Williamson & Wyatt, Portland, filed the brief for respondent.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

In this workers' compensation case, claimant petitions for judicial review of the Workers' Compensation Board's attorney fees award. ORS 656.298. We affirm.

The referee found that claimant's chiropractic care was compensable and set aside employer's denial of payment.[1] The referee awarded claimant $2,000 in attorney fees. ORS 656.386(1). On employer's request for review, the Board affirmed the referee's determination of compensability but awarded only $1,000 in attorney fees for the proceeding before the referee. ORS 656.382(2). The Board awarded an additional $600 in attorney fees for the review proceeding. ORS 656.382(2).

OAR 438-15-010(6) lists factors that the referee and the Board must consider in determining a reasonable attorney fee.[2] The referee made no factual findings as to any of the

[1] At the hearing, claimant stipulated that a separate claim for thermographic testing was noncompensable.

[2] OAR 438-15-010(6) provides:

"In any case where a referee, the Board or a court is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill and standing of the attorneys;

"(e) The nature of the proceedings;

"(f) The result secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

factors. Although the Board purported to consider all of the factors in reducing the referee's attorney fee award by half, it made a specific finding as to only one.[3]

Claimant attacks the Board's fee award as having been made without sufficient factual findings and as being inadequate to compensate his attorney reasonably for the legal services performed. Both parties assume that we review the Board's award of attorney fees according to the "substantial evidence" standard described in *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988), but we do not.

In the past, we have reviewed attorney fee awards for abuse of discretion, reasoning that the Board might "be expected to make consistent and knowledgeable assessments of the attorney effort involved." *Short v. SAIF*, 79 Or App 423, 429, 719 P2d 894 (1986). This is the first time that we have considered that standard of review since the 1987 Legislative Assembly directed us to review workers' compensation cases as provided in ORS 183.482(7) and (8). Or Laws 1987, ch 884, § 12a; ORS 656.298(6).

ORS 183.482(8) requires us to distinguish between three types of agency action in contested cases in order to determine the appropriate standard of review. *Megdal v. Board of Dental Examiners*, 288 Or 293, 318-19, 605 P2d 273 (1980). If a governing provision of law requires a particular action, we review the case to determine whether the agency has committed an error of law. ORS 183.482(8)(a). If a range of discretion in a particular matter has been delegated to the agency by the legislature, we review for abuse of discretion. ORS 183.482(8)(b). We review agency findings of fact to determine whether there is substantial evidence to support them and whether the reasoning from the facts supports the conclusions. ORS 183.482(8)(c); ORS 183.470.

Because the scope of our review depends on the authority delegated to the agency by the legislature, we must look to the words of the delegating statute to determine the nature and scope of that authority. *Springfield Education Assn. v. School Dist.*, 290 Or 217, 222-23, 621 P2d 547 (1980).

The statute authorizing the Board's award of attorney fees in this case provides, in pertinent part: "[T]he employer or insurer shall be required to pay to the claimant or the attorney of the claimant a *reasonable* attorney fee *in an amount set by the board* * * *." ORS 656.382(2). (Emphasis supplied.) We have previously interpreted that language as authorizing the Board to exercise its discretion in setting the

amount of the attorney fee award. *See Short v. SAIF, supra.* The legislature's use of the emphasized "delegative terms" instructs us that the responsibility for determining the

[3] The Board stated:

"* * * * *

"In determining a reasonable attorney fee, the Referee and the Board consider the factors set forth in OAR 438-15-010(6). Generally, results obtained in the form of medical services are considered to be rather modest. * * * In this case, the amount in dispute was $1,582. After considering the above-mentioned factors, we conclude that a reasonable fee at hearing concerning the chiropractic treatment denial issue v $1,000.

"* * * * *."

amount of attorney fees to be awarded in a particular case lies with the Board, not with this court. *Springfield Education Assn. v. School Dist., supra,* 290 Or at 223. Our standard of review is described in ORS 183.482(8)(b):

> "The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:
>
> "(A) Outside the range of discretion delegated to the agency by law;
>
> "(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or
>
> "(C) Otherwise in violation of a constitutional or statutory provision."

The Board's attorney fee award in this case is not defective in any of the ways contemplated by ORS 183.482(8)(b). In particular, contrary to claimant's argument, the Board is not required to make a finding as to each of the factors described in OAR 438-15-010(6); the regulation requires only that the listed factors be considered. The Board's explanation of its award is detailed enough to inform us that it considered all of the factors and had a reasonable basis for its decision. No more is required.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Lonnie A. Rush, Claimant.

ARGONAUT INSURANCE COMPANY et al,
Petitioners,

v.

RUSH,
Respondent.

(WCB 87-09727; CA A49821)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 8, 1989.

Bradley R. Scheminske, Portland, argued the cause for petitioners. On the brief were Thaddeus J. Hettle and Scheminske & Lyons, Portland.

Howard R. Nielsen, Portland, argued the cause and filed the brief for respondent. On the brief was Vick & Gutzler, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

Employer seeks review of an order of the Workers' Compensation Board that reversed the referee's order and found that claimant's medical services claim for a low back injury relates to his accepted work injury. We review for errors of law and substantial evidence and affirm. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

Claimant sustained a compensable on-the-job injury to his low back in June, 1981. He experienced pain that extended down both legs. A March, 1982, determination order awarded temporary disability benefits and 10 percent unscheduled permanent partial disability.

In September, 1982, claimant sustained an off-the-job injury that led to increased back and leg pain. In December, 1982, herniated discs at L3-4 and L4-5 were diagnosed. Employer's insurer denied claimant's aggravation claim. He requested a hearing. The issues at the hearing were the compensability of the aggravation claim, the extent of low back disability and the offset of overpayments. The referee concluded that claimant had failed to prove a causal connection between his condition and his compensable 1981 injury and, therefore, affirmed the denial of the aggravation claim. He also allowed claimant an additional 10 percent unscheduled permanent partial disability.

In April, 1985, claimant began treatment with Dr. Berardi, a chiropractor, for low back pain radiating to both legs. Berardi diagnosed a lumbar strain syndrome and intervertebral disc syndrome. He treated claimant ten to twelve times. The insurer paid for those treatments. Claimant returned to Berardi in February, 1987, for additional treatments. At the time, he was experiencing increased symptoms, again involving his low back and legs. The insurer received Berardi's bills for those treatments but did not pay or deny them. In June, 1987, claimant filed a request for a hearing on the "*de facto*" denial of Berardi's bills.

Employer first assigns as error the Board's failure to bar claimant's current claim for medical services on *res judicata* grounds. In its second assignment, it charges that there was not substantial evidence to support the Board's conclusion that "Dr. Berardi's testimony supports a finding that the

compensable 1981 injury is a material cause of [claimant's] current symptom complex and need for treatment." Because resolution of the second assignment of error simplifies analysis of the first assignment, we address it first.

The only medical evidence concerning the cause of claimant's current symptoms comes from Dr. Berardi. Although there is no contradictory evidence, employer argues that Berardi's testimony is "inconsistent, self-serving and does not establish how the treatment he is providing is related to the compensable 1981 injury as opposed to claimant's non-compensable [1982 injury]." Employer is in essence arguing that Berardi's evidence is not credible. The referee made no findings on credibility, but upheld the insurer's denial on the

basis that the claim was barred by *res judicata*. The Board disagreed with the referee's legal conclusion and found that the evidence supported the claim's compensability.

We do not evaluate the credibility of witnesses. *1000 Friends of Oregon v. LCDC (Lane Co.)*, 305 Or 384, 402, 752 P2d 271 (1988). Instead, we review for substantial evidence; that is, whether "the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c). The Board implicitly believed Berardi's testimony, and that testimony is not so inconsistent that reliance on it is unreasonable. We conclude that the Board's finding that the "compensable 1981 injury is a material cause of [claimant's] current symptom complex and need for treatment" is supported by substantial evidence in the record.

Claimant's current treatments are compensable, if the need for them results from the compensable rather than from the noncompensable condition. The compensable injury need not be either the sole or the most significant cause of the current need for treatment. *Van Blokland v. Oregon Health Sciences University*, 87 Or App 694, 698, 743 P2d 1136 (1987). Consequently, we affirm the Board's conclusion that claimant's medical services claim is compensable.

Employer's first assignment of error, that claimant's medical services claim is barred by *res judicata*, is answered by our conclusion regarding compensability. Employer essentially argues that the condition for which claimant is now receiving treatment is the same condition that was found to be

unrelated to the compensable work injury in the 1983 aggravation hearing. If that were correct, the current claim would be barred, because the issue of the causal relationship between the compensable 1981 injury and the 1982 condition would have been fully litigated in the 1983 aggravation hearing. *North Clackamas School Dist. v. White*, 305 Or 48, 750 P2d 485, *modified* 305 Or 468, 752 P2d 1210 (1988). However, because the Board properly determined that part of claimant's current need for requiring medical services is causally related to the compensable injury, *res judicata* does not bar the claim for those services.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Cleo F. Perry, Claimant.

PERRY,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 85-07195; CA A44205)

On remand from the Oregon Supreme Court, *Perry v. SAIF*, 307 Or 654, 772 P2d 418 (1989).

Judicial Review from Workers' Compensation Board.

Submitted on remand May 31, 1989.

Leo R. Probst, Portland, argued the cause for petitioner. With him on the brief was Leo R. Probst & Associates, Portland.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondents. On the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Darrell E. Bewley, Assistant Attorney General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

This case is on remand from the Supreme Court. The only issue is whether claimant suffered a worsening of his compensable injury under the standard established in *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987). On *de novo* review, we conclude that he has not.[1] We therefore affirm the Workers' Compensation Board order that affirmed the referee's decision upholding SAIF's denial of his aggravation claim.

We quote the facts from our previous opinion:

> "Claimant injured his back on the job in November, 1979. The first determination order respecting the injury was May 14, 1980. After several subsequent reopenings, the claim was finally closed on July 2, 1984, by a stipulated award of 30 percent permanent partial disability. The parties also agreed, as part of the written stipulation, that claimant was not permanently and totally disabled at that time.
>
> "In April, 1985, he was admitted to the hospital for treatment of his low back. His right to file an aggravation claim for the 1979 injury would expire May 14, 1985, and to establish an aggravation, he would have to show a worsening subsequent to the last arrangement of compensation on July 2, 1984. He consistently has refused surgery. On that occasion, he was put in traction, which relieved the pain, and spent about six days in the hospital. He filed a claim for aggravation on May 6, 1985, eight days before his aggravation rights expired. SAIF denied the claim." 93 Or App 631, 633, 763 P2d 736 (1988). (Footnote omitted).

The referee found that claimant had experienced episodes of pain since his last arrangement of compensation, but not a worsening of his underlying compensable condition. The referee, therefore, upheld the denial, and the Board affirmed. On appeal, we reversed and ordered acceptance of the claim. Although we agreed that claimant's underlying condition had

[1] Claimant filed his petition for review before July 20, 1987; therefore, our scope of review is *de novo*. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).

not worsened, we concluded that, under *Gwynn v. SAIF, supra,* claimant had experienced a worsening, because inpatient hospital treatment was required for his compensable

injury. 93 Or App at 634. The Supreme Court reversed and remanded,[2] explaining that

> "the Court of Appeals misapplied the *Gwynn* decision. The Court of Appeals read the above-quoted words 'or becomes an inpatient at a hospital for treatment of that condition' to state an alternative test of aggravation independent of any worsening of the worker's 'underlying condition.' These words expressly referred to an alternative to total disability 'as a result of worsening of the worker's condition from the original injury.' " *Perry v. SAIF,* 307 Or 654, 657, 772 P2d 418 (1989).

Generally, an aggravation claim arises when a compensable injury worsens. ORS 656.273. In remanding, the Supreme Court established that the appropriate test to determine whether a worsening occurred in this case is

> "whether the symptoms such as pain have caused loss of function of the body and resulted in loss of earning capacity." 307 Or at 657.

The referee found that claimant had experienced increased episodes of pain since his last arrangement of compensation. We agree. Claimant's treating physician indicated that he suffered flair-ups of pain requiring treatment. However, claimant testified that those episodes were short in duration and that he went to the hospital only for traction. Nothing in the record suggests that claimant's increased symptoms caused any loss of function of his body that resulted in loss of earning capacity.

Affirmed.

[2] In our original opinion, we concluded that an aggravation claim requires that there have been a worsening before expiration of a claimant's aggravation rights. 93 Or App at 633. That conclusion was not reviewed by the Supreme Court.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

SAIF CORPORATION,
Appellant,
v.
JOHNSON,
Respondent.
(88C-11692; CA A60685)

Appeal from Circuit Court, Marion County.

Duane R. Ertsgaard, Judge.

Argued and submitted July 17, 1989.

Christine Chute, Assistant Attorney General, Salem, argued the cause for appellant. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Susan G. Bischoff, Salem, argued the cause for respondent. With her on the brief were Joseph D. Robertson and Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

SAIF Corporation appeals from a judgment for the defendant Workers' Compensation referee in this mandamus action by which SAIF seeks to have defendant compelled to vacate his order on a claim. The trial court concluded that exclusive jurisdiction to review defendant's order is provided in the Workers' Compensation Law and that the availability of that review provides SAIF with an adequate alternative remedy and therefore makes mandamus unavailable. The court entered a judgment dismissing the alternative writ. We affirm.

The claimant had requested review of four determination orders that were issued between 1984 and 1986. Those requests were dismissed in September, 1987, on the claimant's motion. In February, 1988, another determination order concerning the same claimant was issued. He requested review, and a hearing was conducted by defendant. According to SAIF's petition,

> "Defendant assumed jurisdiction over said February 17, 1988 Determination Order, pursuant to ORS 656.283, and also assumed jurisdiction over the four previously mentioned dismissed Determination Orders.
>
> "VIII.
>
> "* * * Defendant issued an Opinion and Order on the merits of the February 17, 1988 Determination Order, as well as the merits of the four previously mentioned dismissed Determination Orders, on August 16, 1988."

Defendant's order increased the compensation that SAIF was required to pay. SAIF contends that, because there were no pending requests for hearings on the four earlier determination orders and the time allowed for requesting review of them had elapsed, defendant had no jurisdiction to rule on them.

SAIF agrees that defendant's order is reviewable by the Workers' Compensation Board under ORS 656.295. It contends, however, that that is not an exclusive remedy and that it is not an adequate one, because, under ORS 656.313(2), SAIF cannot recover the compensation that it must pay the claimant between the time of defendant's order and the time that the order may be reversed by the Board or us. Defendant

responds that the review provisions of the Workers' Compensation Law are exclusive and adequate. Defendant also suggests that SAIF's inability to recover the payments made during the review process does not render the process an inad-

equate remedy, because the nonrecovery provision of ORS 656.313 is a component of, and not a drawback to, the process. Defendant relies on *Wisherd v. Paul Koch Volkswagen,* 28 Or App 513, 559 P2d 1305, *rev den* 278 Or 393, *appeal dismissed* 434 US 898 (1977), where we said:

> "ORS 656.313 cannot be viewed in isolation; it must be considered as part of the entire workmen's compensation system. The workmen's compensation system compromises many interests of both employers and employes out of the belief that an alternative to judicial determination of employment-related injury claims is necessary. Employes must forego, inter alia, the right to sue in tort for injuries occurring in the course of employment but receive in exchange the elimination of fault as a basis for compensation. Employers receive the benefit of limited liability for compensable accidents but are required on the other hand to assume liability for a greater number of injuries. These and many other balances are among those struck in the *quid pro quo* format of the workmen's compensation system * * *." 28 Or App at 516.

We have repeatedly held that the circuit courts lack jurisdiction to consider matters concerning workers' compensation claims and that the decisional and review provisions of the Workers' Compensation Law are exclusive. *Hayden v. Workers' Compensation Dept.,* 77 Or App 328, 713 P2d 612 (1986); *SAIF v. Harris,* 66 Or App 165, 672 P2d 1384 (1983); *see* ORS 656.018; ORS 656.704. However, we have not previously considered the exclusive jurisdiction question in the context of a mandamus proceeding, nor have we decided the other question that the parties dispute—whether the administrative and judicial review remedies provided by the Workers' Compensation Law are an adequate alternative to and foreclose mandamus. Because the second question is independently dispositive and can be answered solely with reference to this case, we base our decision on it.

ORS 34.110 provides, in part:

> "The writ shall not be issued in any case where there is a plain, speedy and adequate remedy in the ordinary course of the law."

It is clear that defendant's order decides matters concerning a claim, that SAIF can—and has—sought Board review of the order and that the specific question that SAIF wants decided here, whether defendant exceeded his jurisdiction, can be decided by the Board in its review of the order pursuant to ORS chapter 656. The relief that SAIF seeks in this action, that defendant's order be vacated, is the functional equivalent of relief that it could seek, for the same reason and possibly others, in the Board proceeding. SAIF does not argue that anything inherent in the two kinds of proceedings makes mandamus so much speedier than review under the Workers' Compensation Law provisions that the latter are inadequate for that reason. Moreover, the dispatch of mandamus has generally not led the courts to hold that a direct review or appeal is an inadequate alternative, even when mandamus is sought in connection with a preliminary matter and the appeal must await a final disposition. *See State ex rel Automotive Emporium v. Murchison,* 289 Or 265, 611 P2d 1169, *rehearing denied* 289 Or 673, 616 P2d 496 (1980).

Against that background, it is far from apparent why SAIF regards the statutory review procedure as inadequate. SAIF relies on *State ex rel Huntington v. Sulmonetti*, 276 Or 967, 557 P2d 641 (1976), where the court reached the merits of and rejected the employer-relator's substantive ground for seeking mandamus to require the defendant circuit court judge to vacate his order remanding a claim to the Board. The employer argued that the claim was barred by *res judicata*, and the Board had agreed. On direct review, the defendant disagreed and remanded "for a determination of whether claimant was in the course and scope of his employment when he sustained his accidental injury." 276 Or at 969. The Supreme Court held that the claim was not barred and refused to enter a peremptory writ. However, it noted at the conclusion of its opinion:

> "Defendant contends that the proceeding should be dismissed and that mandamus will not lie because there is an adequate remedy by way of appeal upon completion of the litigation. The employer contends that an appeal is not an adequate remedy because if, after remand by the circuit court, it was found that claimant was injured in the course of his employment, he would draw benefits during the pendency of an appeal which could not be recovered if the employer was

> subsequently to win on the issue raised here. ORS 656.313. At the time of issuance of the alternative writ we deemed this possibility to be sufficiently likely to make an appeal in the usual course of law an inadequate remedy." 276 Or at 973.

This case differs from *Huntington*. Had the court concluded that *res judicata* barred the claim there, its issuance of a peremptory writ would have eliminated the remand to the Board and ended the proceedings on the claim before any compensation subject to ORS 656.313 was awarded. Here, conversely, the mandamus relief that SAIF seeks would not end the proceedings on the claim, because the claimant's request for hearing on the 1988 determination order would still be viable. Indeed, the relief sought by SAIF—vacation of defendant's order—could lengthen the proceedings on the claim. Defendant would have to issue a new order, while, in the present posture of the proceedings, the Board can review the existing order *de novo* and make its own findings concerning compensation, without further involvement of defendant.

A second distinction is that SAIF is *presently* required to make nonrecoverable payments, while in *Huntington* the prospective possibility of such an obligation arose only by virtue of the remand that the employer sought to prevent in the mandamus proceeding. Further Board action was the source of the threatened error in *Huntington;* here, Board review is the direct means for correcting the error that SAIF ascribes to defendant's order.

After the decision in *Huntington*, the legislature amended ORS 656.298 to make Board orders directly reviewable by this court rather than the circuit court. Or Laws 1977, ch 804, § 11. One of the necessary effects of that amendment was to expedite the workers' compensation review process by

eliminating one tier of review. Paradoxically, SAIF would put the circuit court back into the position of deciding questions that are capable of decision in the statutory review process and would justify that result by saying that the review process is not a plain, speedy and adequate alternative to the circuit court remedy. The net effect is illustrated by this case: If we were to afford the relief that SAIF seeks, the same or similar

questions would have been presented to four different decisionmakers,[1] and the review proceedings on the claim would be back at the starting point.

SAIF seems to understand *State ex rel Huntington v. Sulmonetti, supra,* as stating a universal proposition that an employer or insurer that is required to pay nonrecoverable interim compensation lacks an adequate alternative remedy *per se* and may proceed by mandamus instead of following the statutory review procedures. We read *Huntington* far more narrowly to address only its own facts. If it were read otherwise, it would amount to a judicial repeal of the workers' compensation review statutes as they apply to employers and insurers.

SAIF also argues that mandamus should be available, because the question it raises is a jurisdictional one (at least by SAIF's definition). SAIF relies on *State ex rel Automotive Emporium v. Murchison, supra,* where the court said:

> "Direct appeal is an adequate remedy unless the relator would suffer a special loss beyond the burden of litigation by being forced to trial.[5] * * *

> "[5] An exception exists where the relator asserts that a court is improperly asserting jurisdiction, *State ex rel Knapp v. Sloper,* 256 Or 299, 473 P2d 140 (1970), *State ex rel Handly v. Hieber,* 256 Or 93, 471 P2d 790 (1970). * * *" 289 Or at 269.

In both cases that *Murchison* cites for the proposition that mandamus lies to correct an improper assertion of jurisdiction, the issue was whether the defendant judge could be compelled to quash the service of summons. The court explained in *State ex rel Knapp v. Sloper, supra,* that, although a direct appeal is an adequate remedy to redress the erroneous allowance of a motion to quash:

> "If, on the other hand, the motion to quash is denied, appeal is not an entirely adequate remedy. Since 1949 the defendant may enter a general appearance without waiving his objection to the service and if after trial a judgment is entered against him he may appeal and in the appellate court renew his challenge of the service. ORS 16.150. If the appellate court holds the service defective the trial of the case has

> been a waste of time and money for both parties and court. There is good reason to decide at the outset whether the trial will be a wasted effort or will decide the controversy." 256 Or at 301.

The situation here is not comparable. Defendant has not simply asserted that he *has* jurisdiction; he has completed his *exercise* of jurisdiction. After-the-fact review rather than

[1] Direct Board review of the order is being pursued by both claimant and SAIF.

prevention is all that *can* be obtained through *any* procedure. The procedures of the Workers' Compensation Law are designed for and are completely adequate to provide that review.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Woodie R. Striplin, Claimant.

EVANITE FIBER CORPORATION et al,
Petitioners,

v.

STRIPLIN,
Respondent.

(WCB 87-12406; CA A51263)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 19, 1989.

Jenny A. Ogawa, Salem, argued the cause for petitioners. With her on the brief was Kevin L. Mannix, P.C., Salem.

Kathryn Ricciardelli, Salem, argued the cause for respondent. With her on the brief were Randy M. Elmer and Vick & Gutzler, Salem.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

GRABER, P. J.

Affirmed.

GRABER, P. J.

Employer seeks review in this workers' compensation case. We review for substantial evidence and errors of law, ORS 656.298(6), and affirm.

Claimant sustained a low back injury on December 8, 1984, while working as a paper machine operator. He sought treatment from a chiropractor, who diagnosed a lumbosacral sprain and found that claimant had a preexisting mild to moderate degenerative condition. In January, 1985, employer accepted the claim as a disabling injury. Claimant complained of various mild recurrences and experienced two episodes of increased severe low back pain in June and July, 1985, each of which resulted in time loss. He continued chiropractic treatments. They gradually decreased from five times per week immediately after the injury to one to three times per week, until claimant went without treatments for a one-month period in June and July, 1987.

On July 28, 1987, employer's insurance carrier sent claimant a letter that denied

"all further chiropractic care in that it is not reasonable, necessary, or attributable to our industrial injury of December 8, 1984. All chiropractic care obtained prior to this date will be paid for. However[,] we will not make payments for any chiropractic care past this date."

Claimant requested a hearing. The referee set aside the denial in December, 1987, finding that

"[c]laimant has met his burden of proving that continued chiropractic treatment is reasonable and necessary and related to the industrial injury."

In July, 1988, a determination order closed the claim and awarded claimant four percent unscheduled permanent partial disability.

Employer sought review of the referee's order. The Board affirmed, but for a different reason. It concluded:

"The employer argues that claimant's ongoing chiropractic care is not related to his compensable 1984 injury. We have found as fact that claimant's ongoing low back symptoms are solely related to his noncompensable degenerative condition. *However, notwithstanding this finding, the employer is prohibited from issuing its partial denial so long as the accepted*

claim is in open status. See Guerrero v. Stayton Canning Co., 92 Or App 209, 212-13[,757 P2d 873] (1988), and cases cited therein. The evidence indicates that the claim was still open as of the date of the denial. The employer's partial denial is therefore procedurally improper." (Emphasis supplied.)

Employer asked the Board to reconsider its order. On reconsideration, the Board adhered to and republished its holding. It added that employer's denial was not effective even upon closure of the claim, because

"the claim here was closed more than seven months following the hearing. Consequently, claimant did not have an opportunity to litigate the compensability of his post-closure treatments."

Employer petitions for review, assigning as error that the Board "decid[ed] the case on procedural grounds instead of deciding the merits of the [employer's] denial." Citing *Boise Cascade Corp. v. Katzenbach,* 307 Or 391, 768 P2d 395 (1989), employer argues that the Board erred in relying on *Guerrero v. Stayton Canning Co.,* 92 Or App 209, 757 P2d 873 (1988).[1] Employer asserts that its "partial denial" was proper, because the denied condition was separable from the accepted condition, and that the Board should have held in its favor on the merits.

We need not reach that argument. Both employer and the Board mischaracterize what happened as a "partial denial." A partial denial occurs "when a claimant makes a single claim encompassing two separate injuries or conditions, * * * [and the employer] partially den[ies] that claim by specifically denying one injury or condition while accepting the other." *Johnson v. Spectra Physics,* 303 Or 49, 58, 733 P2d 1367 (1987). In this case, employer did not specifically deny

[1] In *Guerrero,* we held that "[a]n employer may not issue a partial denial of a previously accepted inseparable condition while the claim is still open." 92 Or App at 212.

any injury or condition. Rather, it denied "all future chiropractic care" on the basis that the care would not relate to the previously accepted claim.

That denial was improper for reasons that the Board did not address. An employer has authority to deny a *current* claimed need for medical services, or specific claims as the

claimant presents them, if the medical services are not reasonable and necessary and attributable to the compensable injury. ORS 656.245(1); *Stratis v. Georgia-Pacific Corp.*, 94 Or App 781, 767 P2d 934, *on reconsideration* 96 Or App 706, 710, 773 P2d 821, *rev den* 308 Or 331 (1989); *Ellis v. McCall Insulation*, 93 Or App 188, 190, 761 P2d 6 (1988), *aff'd* 308 Or 74, 775 P2d 316 (1989); *see also* ORS 656.313(3). However, an employer may not deny its *future* responsibility for payment of benefits relating to a previously accepted claim, unless it follows the statutory procedure for claim closure. *Webb v. SAIF*, 83 Or App 386, 731 P2d 1054 (1987); *Roller v. Weyerhaeuser Co.*, 67 Or App 583, 679 P2d 341, *on reconsideration* 68 Or App 743, 683 P2d 554, *rev den* 297 Or 601 (1984).[2] Employer here tried to deny the claim prospectively, because it denied future medical benefits, not just a separate, noncompensable condition.

Even after claim closure, an employer cannot deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); *Bowser v. Evans Product Company*, 270 Or 841, 530 P2d 44 (1974); *Wait v. Montgomery Ward, Inc.*, 10 Or App 333, 338, 499 P2d 1340, *rev den* (1972). Therefore, the Board also reached the right result when it held on reconsideration that employer's denial remained ineffective after closure of the claim. We affirm the Board's order on review and its order on reconsideration, because employer issued an improper prospective denial.[3]

Affirmed.

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[2] *Compare Chaffee v. Nolt*, 94 Or App 83, 764 P2d 600 (1988), in which we held that the Board properly concluded that the claim was not compensable, even though the employer had issued an improper prospective denial. We reasoned that the employer had closed the claim "immediately after the issuance of the denial," so its conduct was neither unreasonable nor designed to shortcut the process of claim closure. 94 Or App at 85. Here, in contrast, the claim was not closed until the determination order of July 14, 1988, nearly a year after employer issued its denial.

[3] Employer's other arguments require no discussion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Mary E. Williams, Claimant.

WILLIAMS,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(87-00078; CA A50956)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 19, 1989.

Darris K. Rowell, Salem, argued the cause and filed the brief for petitioner.

Yuan Xing Chen, Certified Law Student, Salem, argued he cause for respondent SAIF. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Ann Kelley, Assistant Attorney General, Salem.

No appearance for respondent Hill Investments.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Reversed and remanded.

EDMONDS, J.

Claimant seeks review of an order of the Board that adopted the referee's order that dismissed with prejudice claimant's request for a hearing. We reverse.

Claimant's attorney appeared for the hearing without claimant and moved for a postponement. The motion was denied. He moved to dismiss claimant's request for a hearing without prejudice. That motion was also denied. Finally, he requested that claimant be allowed to proceed on the record[1] and to give her testimony over the telephone. The referee denied the motion and granted SAIF's motion to dismiss with prejudice because of claimant's failure to appear personally and to make herself available for cross-examination. Claimant argues that the referee was without authority to deprive her of the opportunity to put on evidence.

At the time of the hearing, OAR 438-06-071 provided:[2]

[1] The record contained 38 documents.

[2] OAR 438-06-071 became effective within days before claimant's hearing. Previously, the applicable rule provided:

"Failure of a party to appear at a hearing without good cause constitutes a waiver of appearance. If the party failing to appear is the party that requested the hearing, the request for hearing may be dismissed unless good cause is shown and the other party is not prejudiced thereby."

"(1) A req for h ring may be dism l if a referee finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days.

"(2) Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the referee shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

SAIF does not argue that there is a jurisdictional requirement for appearance of a claimant who has requested a hearing, but argues that ORS 656.283(7), which provides that hearings shall be conducted "in any manner that will achieve

substantial justice," authorizes a referee to dismiss with prejudice, if the claimant does not personally appear. SAIF argues that "substantial justice" includes an opportunity to confront and cross-examine an adverse party before there can be a factual decision on that party's claim.

However, ORS 656.283(7) also states:

"Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing * * *."

ORS 656.283(7) ensures that all parties will have the opportunity to present their evidence. Although a claimant may choose to present evidence through her own testimony, her choice not to do so does not prevent the insurer from presenting its evidence in defense of her claim. OAR 438-06-071 contemplates that a request for a hearing may be dismissed with prejudice if neither a claimant nor a claimant's attorney appear for hearing. Nothing in the rule authorizes the referee to dismiss the request simply because the claimant does not appear. Under the Board's rules, claimant was entitled to offer the remainder of her evidence, even if she chose not to testify personally. The referee erred when it denied her that opportunity.[3]

Reversed and remanded.

[3] We need not address claimant's other assignments.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Tony Mullins, Claimant.

BEAR SPRINGS FOREST PRODUCTS et al,
Petitioners,

v.

MULLINS,
Respondent.

(86-04114; A50688)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 9, 1989.

Craig A. Staples, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Daniel C. Lorenz, Portland, argued the cause for respondent. With him on the brief was Des Connall & Dan Lorenz, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded for reconsideration.

BUTTLER, P. J.

Employer seeks review of the Workers' Compensation Board's order setting aside its denial of a claim on the ground that it was an improper partial denial.

Claimant injured his knee on the job and filed a claim. Employer responded:

> "You filed a claim for workers' compensation benefits related to an injury sustained to your right knee. Your claim was originally placed into a deferred status, and time loss benefits were paid.
>
> "At this time, I have had an opportunity to review the medical information currently available to me. Based on the current medical information, it does appear that your current condition relates primarily to your preceding injury and surgeries. The medical information indicates that your recent twisting injury merely caused a temporary aggravation of your problem, rather than a material worsening to your underlying condition. Based on this information, we are unable to accept your claim for workers' compensation benefits, as it is felt that your primary need for treatment is related to your pre-existing condition. Therefore, without waiving further questions of compensability, this formal denial of the above-referenced claim is made."

Claimant requested a hearing. Employer then conceded that a portion of the claim, *i.e.*, a "contusion," might be compensable but continued to deny responsibility for all of claimant's knee condition, on the ground that his disability is caused by a preexisting condition.

The Board held that employer's letter was a partial denial that failed to comply with the requirements stated in its opinion in *Bryan D. Warrilow*, 40 Van Natta 521 (1988), that a partial denial be preceded or accompanied by an acceptance. We reversed that decision in *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, 771 P2d 295, *rev den* 308 Or 184 (1989), holding that a partial denial is legally sufficient if it is clear what portion of the claim is denied.

Admittedly, the wording of employer's denial suggests that a portion of claimant's condition may be compensable: "[Y]our recent twisting injury merely caused a temporary aggravation of your problem." However, there is no doubt, and claimant concedes, that employer's letter denied the claim *in*

toto; therefore, the Board's reliance on its opinion in *Warrilow*, even if that decision had been correct, is misplaced. There is no procedural reason why the denial itself was improper. Employer's later concession at the hearing that a portion of the claim may be compensable does not invalidate the earlier denial on the procedural basis on which the Board relied. We remand the case for reconsideration on its merits.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Donald E. Lowry, Claimant.

LOWRY,
Petitioner,

v.

DU LOG, INC., et al,
Respondents.

(87-01224; CA A50750)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 20, 1989.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief were Jon C. Correll and Malagon, Moore & Johnson, Eugene.

David O. Wilson, Employers Defense Counsel, Eugene, argued the cause for respondents. With him on the brief were Phillip Nyburg, Eugene.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

Claimant seeks review of an order of the Workers' Compensation Board determining that his benefits for temporary disability should be calculated pursuant to *former* OAR 436-60-020.

The Board found that claimant was paid for the number of hours that he actually worked, that, at the time he was injured, he had been working for employer for over four months, five to six days per week, averaging more than nine hours per day, and that employer expected him to be available for full-time work. There is substantial evidence to support those findings.

Employer initially paid claimant time loss benefits for his injury at a rate of $285.01 per week, calculated pursuant to ORS 656.210(2)(a)(C):

> "For the purpose of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving:
>
> "* * * * *
>
> "(C) By 5, if the worker was regularly employed five days a week."

Claimant complained that that rate of benefits was too low, in that it did not reflect his overtime wages. Employer then recalculated claimant's benefits by averaging his wages pursuant to *former* OAR 436-60-020, which provided, in part:

> "(4) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined in the following manner:
>
> "(a) Employed on call basis: Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than last 4 weeks of employment to arrive at average. For workers employed less than 4 weeks, or where extended gaps exist within the 4 weeks, use intent at time of hire as confirmed by employer and worker.
>
> "* * * * *
>
> "(c) Employed varying hours, shifts or wages: Use average as in subsection (a).
>
> "* * * * *

> "(i) Employed with overtime: Overtime shall be considered only when worked on a regular basis. Overtime earnings shall be considered at the overtime rate rather than straight time."

That calculation resulted in weekly benefits of $264.17. Claimant now contends that his weekly wage should be calculated pursuant to ORS 656.210(2) and not under the administrative rule.

Employer concedes that claimant was "regularly employed," as that term is defined and used in ORS 656.210(2)(c):

> "As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed *and for workers with no remuneration or whose remuneration is not based solely upon*

daily or weekly wages, the director, by rule, may prescribe methods for establishing the worker's weekly wage." (Emphasis supplied.)

It argues, however, that because claimant was paid by the hour, rather than by the day or week, his benefits are properly computed pursuant to *former* OAR 436-60-020, based on the actual hours he worked. Claimant does not challenge employer's computation under the rule. He contends only that, under ORS 656.210(2)(c), a worker is either "regularly employed" and gets benefits calculated pursuant to ORS 656.210, or is one whose remuneration is not based solely on daily or weekly wages and whose benefits are calculated pursuant to the rule, but cannot be both. We agree with the Board. The statute provides that one who is "regularly employed" may also be one who is paid on other than a daily or weekly basis. In such a circumstance, the statute authorizes the director to prescribe the method of establishing the worker's weekly wage. The director has done that, and claimant's benefits were properly calculated under *former* OAR 436-60-020.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

PROGRESSIVE CASUALTY INSURANCE CO.,
Respondent,
v.
MARCA,
Defendant,
and
SMISEK,
Appellant.
(88CV0218; CA A49505 (Control))

SMISEK,
Appellant,
v.
MARCA,
Respondent.
(87CV1138; CA A50401)
(Cases Consolidated)

Appeal from Circuit Court, Coos County.

Richard L. Barron, Judge.

Argued and submitted September 13, 1989.

James C. Coffey, North Bend, argued the cause for appellant. With him on the briefs was Hayner, Stebbins & Coffey, North Bend.

Michael A. Lehner, Portland, argued the cause for respondent Progressive Casualty Insurance Co. With him on the brief was Lehner & Mitchell, Portland.

Gig Wyatt, Salem, argued the cause for respondent Marca. On the brief was J. P. Harris, II, Salem.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

GRABER, P. J.

Reversed and remanded.

GRABER, P. J.

These consolidated cases arise from the death of Kevan Robbins. The personal representative of Robbins' estate (the estate) claims damages for wrongful death from Marca, Robbins' employer. Progressive Casualty Insurance Co. (Progressive), Marca's liability insurer, seeks a declaratory judgment that Robbins' fatal injuries occurred in the course of his employment and were, therefore, excluded from coverage under its policy.[1] The estate intervened in the declaratory judgment action.

The parties to the declaratory judgment action tried the case to the court. They stipulated that the evidence consisted of Marca's deposition and the pertinent parts of the insurance policy. The court found "that Robbins was an employee working in the course and scope of employment for defendant Marca at the time of his death" and held that Progressive had no duty to defend or indemnify Marca in the wrongful death action. The estate appeals the declaratory judgment; Marca does not.

In the wrongful death case, the parties stipulated that the ruling in the declaratory judgment action collaterally estopped them from relitigating the issue of Robbins' employment status at the time of his death.[2] They also stipulated that "Marca was a complying employer under Oregon worker's [*sic*] compensation law." The court granted a summary judgment to Marca on the ground that ORS 656.018 bars the claim. The estate appeals.

We first consider the procedural questions that respondents raise. Marca argues that the stipulation in the

wrongful death case means that the estate "agreed not to argue that [Robbins] was not an employee." In other words, according to Marca, the estate conceded the case on the merits and cannot contest the trial court's decision on appeal. Marca relies on this passage in the stipulation:

> "The parties further stipulate and agree that plaintiff is collaterally estopped from arguing, in this case, that [Robbins] was not an employee of Defendant Raymond D. Marca based upon the court's ruling in *Progressive v. Marca, supra.*"

---

[1] The policy in effect at the time of the accident provided, in pertinent part:

"We do not cover:

"* * * * *

"(6) Bodily injury to an employee of an insured arising in the course of employment. This exclusion does not apply, however, to bodily injury to domestic employees who are not entitled to workers' compensation benefits."

See ORS 656.005(7); ORS 656.018.

[2] For the purpose of analyzing these cases, the parties agree that the phrase "arising out of and in the course of employment" in ORS 656.005(7) has the same meaning as the phrase "arising in the course of employment" in policy exclusion number 6.

Marca reads that sentence out of context. A stipulation is binding for the purpose for which it is intended. *McKean v. Bernard,* 54 Or App 540, 546, 635 P2d 673 (1981). In this case, the intent was simply to streamline the proceedings; the estate did not agree to the correctness of the trial court's ruling. Indeed, the stipulation noted that the estate had appealed from the judgment in the declaratory judgment action and stated that the wrongful death action was barred "unless an appellate court should overrule" the trial court. The parties contemplated that both cases could be appealed on their merits.

In the declaratory judgment action, Progressive contends that the estate cannot obtain review,[3] because the insured did not appeal. Progressive asserts that the estate's rights are only derivative; "[i]t has no direct claim against the policy." When Marca chose not to appeal, says Progressive, "the absence of coverage [was] conclusively established for all purposes." Progressive relies on *State Farm Fire & Casualty v. Reuter,* 299 Or 155, 700 P2d 236 (1985), and *Grange Insurance Association v. Beleke,* 90 Or App 416, 752 P2d 864, *rev den* 306 Or 101 (1988), neither of which considered whether a potential judgment creditor who is a party to a declaratory judgment action may challenge an adverse ruling on appeal when the insured does not. The controlling precedent is *Viking Ins. Co. v. Petersen,* 96 Or App 46, 49-50, 771 P2d 1022, *rev allowed* 308 Or 197 (1989), where we held that a potential judgment creditor who is a party to a declaratory judgment action can obtain review of a question of law, even if the insured chooses not to appeal. Marca's failure to appeal does not prevent the estate from obtaining review of the scope of insurance coverage.

We turn to the merits and, as a preliminary matter, define the scope of our review. The declaratory judgment action was tried on stipulated facts, Marca's deposition and provisions of the insurance policy. The deposition is internally consistent. That being so, this is a case in which the facts are undisputed.

> "The question of a person's employment status is for the trier of fact, if the facts surrounding the arrangement between the parties are in dispute. When there is no dispute, and the parties merely disagree about the legal consequences of the agreed facts, the question is one for the court." *Blacknall v. Westwood Corporation,* 89 Or App 145, 147, 747 P2d 412 (1987), *aff'd* 307 Or 113, 764 P2d 544 (1988). (Citations omitted.)

Accord: Hendrickson v. Lewis, 94 Or App 5, 764 P2d 577 (1988).

Robbins worked on Marca's dairy farm as a milker and general helper. On Mondays, Tuesdays, Thursdays, and Fridays, he did various chores, such as fix fences and irrigate land, from noon to 4 p.m. and milked cows from 4 p.m. to 8 p.m. On weekends, he milked from 5 a.m. to 9 a.m. and again from 4 p.m. to 8 p.m. He took Wednesdays off. For his work, Robbins received $550 per month and the use of a mobile home.

[3] Progressive's argument is not jurisdictional; it challenges the estate's ability to obtain review of the merits of the trial court's decision.

Robbins died on a Saturday, between his split shifts. Some time between 10 a.m. and 11 a.m. that day, Robbins accompanied Marca to another person's farm, several miles away, to help Marca and Marca's father salvage some lumber from a barn that was soon to be razed. Robbins and Marca had begun to dismantle the barn earlier and had worked on it together two to four times, during Robbins' regular working hours. Marca took his share of the lumber back to his farm and kept it for future farm use; some of the wood was suitable for mending fences, for instance.

This time, Marca asked Robbins for help when Robbins was at his trailer during his time off. Marca testified that it was his father's idea to finish the work then, because the barn was about to be burned:

> "I told my dad I didn't really want to go and it was [Robbins'] day off and I just didn't care to go that day. But he said he was going to go ahead and go over there anyway."

Out of concern for his elderly father, Marca decided to help, whether or not Robbins agreed to go along. Marca wanted Robbins to go with him, because "he was helping me on the job through the week or during his work hours" and because Marca had given him permission to salvage some piping and concrete blocks for himself. Robbins did not receive additional compensation for the task, and he would not have been fired if he had refused to do it.

At the barn, Robbins and Marca worked with Marca's father loading lumber into Marca's truck until about 2 p.m. No one was in charge of the salvage operation.

> "[Robbins] said that he had dismantled buildings for a living for a period of time. So he would know just as much about it as I did. My dad knew just as much about it as I did, so we were all kind of a teamwork-type situation."

After removing the wood, the three men attempted to tow an abandoned tractor, to allow access for the fire department that was going to burn the barn. Marca did not know which fire department was to burn the barn. He explained:

> "Q. Now, you said, mentioned earlier in your testimony that someone asked you or you were asked about moving this tractor, do you recall saying that to me earlier?
>
> "A. Yes, I do and I should go over that. That was my dad that asked me.
>
> "Q. Okay. When did he ask you about moving the tractor, was it on December 21 [the date of Robbins' death]?
>
> "A. I'm not sure. It might have been December 21 but it might have been a few days before but the tractor had to be moved before we left the job, it was part of the job to move the tractor.
>
> "Q. Why was that?
>
> "A. To move it out of the way so the fire truck could have access to the area.
>
> "Q. All right. Does your father have any relationship to the Coquille Rural Fire Department at all? Is he involved in that organization in any way?
>
> "A. Yes.

"Q. In what capacity or does he have a capacity?

"A. He is with the rural fire, Coquille Rural Fire District.

"Q. Is he actually a volunteer fireman himself or do you know?

"A. No, not a volunteer fireman.

"* * * * *

"Q. All right. And when you first undertook to move the tractor in relationship to the work you were doing earlier, salvaging boards and so on and so forth, was [moving the tractor] the last thing you were going to do that day?

"* * * * *

"A. Yes."

Marca's father said, "It's time to move the tractor." The three men undertook a cooperative effort to move it. Robbins was killed at about 2:30 or 3 p.m., when the tractor flipped over on him.

We recently stated the applicable principles this way:

"The ultimate inquiry under [the workers' compensation] statute is whether 'the relationship between the injury and the employment [is] sufficient that the injury should be compensable * * *.' *Rogers v. SAIF*, 289 Or 633, 642, 616 P2d 485 (1980). We have identified the following factors to help determine whether an injury is work-related:

"'(a) Whether the activity was for the benefit of the employer * * *;

"'(b) Whether the activity was contemplated by the employer and the employe either at the time of hiring or later * * *;

"'(c) Whether the activity was an ordinary risk of, and incidental to, the employment * * *;

"'(d) Whether the employe was paid for the activity * * *;

"'(e) Whether the activity was on the employer's premises * * *;

"'(f) Whether the activity was directed by or acquiesced in by the employer * * *;

"'(g) Whether the employe was on a personal mission of his own * * *.' *Jordan v. Western Electric*, 1 Or App 441, 443-44, 463 P2d 598 (1970). (Citations omitted.)

"All of those factors may be considered, and no one factor is dispositive. *Mellis v. McEwen, Hanna, Gisvold*, 74 Or App

571, 575, 703 P2d 255, *rev den* 300 Or 249 (1985)." *Preston v. SAIF*, 88 Or App 327, 330, 745 P2d 783 (1987).

Applying that standard, we hold that Robbins' injury did not arise in the course of his employment by Marca.

The trial court correctly determined that the *salvage work* was a part of Robbins' employment. He was not paid for that work; it occurred outside of regular working hours; and it took place away from the employer's property. Those factors weigh against the conclusion that the demolition of the barn

was in the course of employment. On the other hand, the remaining factors weigh more heavily on the other side. The salvage operation was for Marca's benefit, albeit not for his exclusive benefit, because he intended to use the materials in his dairy business; Marca and Robbins specifically contemplated that Robbins would assist in demolishing the barn; obtaining lumber that could be used in the dairy business was incidental to Robbins' employment as a farm hand; Marca requested, and thereby acquiesced in, Robbins' participation in the salvage work; and Robbins was not on a personal mission, even though he also planned to benefit incidentally. He went to the salvage site only at his employer's express request and in his employer's company.

Moving the tractor, however, was not shown to be an integral part of the salvage project and, therefore, was not a part of Robbins' employment.[4] On this record, moving the tractor was entirely for the benefit of the fire department, not Marca. Although earlier parts of the demolition had been done during Robbins' regular hours, there is nothing in the record to suggest that the tractor would have been moved during his regular working hours and nothing to suggest that Marca and Robbins specifically contemplated ahead of time that Robbins would help move the tractor. The record does not suggest that working around and moving tractors or similar equipment was an ordinary risk of Robbins' regular work as a farm hand. He was not acting in the course of his employment when he died.

Reversed and remanded.

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[4] The trial court found

"that the tractor moving was part of the salvage agreement. For allowing the defendant Marca to salvage, the landowner wanted the tractor moved."

That finding apparently responded to an *argument* made to the court, but nothing in the *record* supports it. Progressive, as the "petitioner in a suit for declaratory relief[,] has the burden of proof as in any other suit." *Kassel v. City of Salem,* 34 Or App 739, 742, 579 P2d 875 (1978).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

MARTELLI,
Appellant,
v.
R.A. CHAMBERS AND ASSOCIATES,
Respondent.

(87 1402; CA A49992)

Appeal from Circuit Court, Linn County.

William O. Lewis, Judge.

Argued and submitted June 19, 1989.

Edward Harri, Salem, argued the cause for appellant. On the briefs were James C. Egan and Emmons, Kyle, Kropp, Kryger & Alexander, P.C., Albany.

Lloyd W. Helikson, Eugene, argued the cause for respondent. On the brief were William G. Wheatley and Jaqua & Wheatley, P.C., Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

In this action for damages for personal injuries, plaintiff appeals from a summary judgment for defendant granted on the ground that defendant is immune from liability by reason of the Workers' Compensation Law. ORS 656.018. We reverse.

At the time of plaintiff's injury, defendant was the general contractor for renovation of a hospital. Associated Sheet Metals, Inc., (Associated) subcontracted directly with defendant to do sheetmetal work on the project for $60,500. Defendant also contracted with Bowen Brothers, Inc., as a subcontractor to do the major part of the renovation. Bowen Brothers, Inc., then also subcontracted with Associated for other sheetmetal work at a unit price of approximately $233,000. Associated agreed to maintain workers' compensation insurance for its employes.

Plaintiff was employed by Associated and alleged that he was injured while working for Associated on the hospital job site when a set of wooden steps that he was ascending gave way. He alleged that defendant had constructed the stairway and was in charge of and had control of the work site.

Defendant filed various motions pursuant to ORCP 21, and some of them were allowed. It did not file an answer, but moved for summary judgment, contending that it was immune from liability under the Workers' Compensation Law. The only evidence material to that issue that was submitted by defendant in two affidavits describing the subcontracts executed by defendant and Associated, copies of the various subcontracts and certificates that Associated had workers' compensation coverage. Plaintiff did not file a written response or any evidence. There was a hearing on the motion that is not a part of the record.

Plaintiff's essential argument is that defendant is not his employer and, therefore, does not qualify for statutory immunity. He contends that there is a fact issue as to whether he is a subject worker of defendant under ORS 656.005(13) and ORS 656.005(27). Defendant initially argues that plaintiff did not preserve the challenge that he makes on appeal, because the record does not show that he made any factual or

legal challenge to defendant's motion. Defendant had the burden to establish that summary judgment was appropriate because there is no issue as to a material fact and that it was entitled to judgment as a matter of law. Plaintiff's failure explicitly to challenge the factual basis and the issue of law below does not preclude him from arguing on appeal that defendant did not meet its burden. *McKee v. Gilbert*, 62 Or App 310, 661 P2d 97 (1983).

ORS 656.018(1) provides that workers' compensation is an employer's only liability for a compensable injury to a "subject worker," and ORS 656.018(2) provides generally that benefits under the act are an injured worker's exclusive remedy against "the worker's employer" for a compensable injury. The exclusivity of the remedy and the limitation of liability is applicable when a worker-employer relationship exists. The two elements necessary to create the relationship, *i.e.*, to make plaintiff a "subject worker" of defendant, are whether defendant had contracted to pay "a remuneration for and secure the right to direct and control the services" of plaintiff. ORS 656.005(13); ORS 656.005(27).

Defendant points to its contract with Associated and argues:

> "Defendant's payment of the subcontractor price to Associated, who in turn paid plaintiff for his services, was sufficient remuneration by the defendant for the services of the plaintiff."

Although the lack of a direct transfer of funds between the parties is not determinative, "remuneration" contemplates a more direct *quid pro quo* between payment and services than the possibility that plaintiff's compensation as a worker will ultimately come from the contract payment to his employer. *See Childress v. Short*, 71 Or App 150, 691 P2d 109 (1984). Defendant presented no evidence regarding payment other than the contract between it and Associated, which called for certain work to be done by Associated for a single stated price. Under this state of facts, defendant was not plaintiff's employer and plaintiff was not a subject worker of defendant.

Defendant argues in the alternative that it should have the same immunity as plaintiff's employer, because it is potentially liable for workers' compensation for plaintiff

under ORS 656.029 and ORS 656.556.[1] It argues that, if it is secondarily liable for compensation to a worker, it should also have the immunity from civil action accorded the worker's primary employer. Whatever might be the virtues of such a policy, immunity is based on an employer-worker relationship, and neither statute creates that relationship.

Reversed and remanded.

---

[1] ORS 656.029(1) provides, in part:

> "If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals * * * who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences."

ORS 656.556 is to a similar effect.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Sheri L. Robertson, Claimant.

ROBERTSON,
Petitioner,

v.

DAVCOL, INC., et al,
Respondents.

(TP-88017; CA A50726)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 9, 1989.

Karen M. Werner, Eugene, argued the cause and filed the brief for petitioner. With her on the brief was Peter O. Hansen, Portland.

David 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 Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded with instructions to make distribution order to claimant.

BUTTLER, P. J.

Claimant seeks review of an order of the Workers' Compensation Board holding that the entire proceeds of a third party settlement are subject to SAIF's third party "lien" and that a distribution pursuant to ORS 656.593(1) is "just and proper."[1]

Claimant was injured on the job when she slipped and fell on employer's floor, as a result of which she underwent low back surgery. Because her employer was a non-complying employer, her worker's compensation claim was referred to SAIF for processing. ORS 656.054. SAIF accepted the claim and, as the paying agent, has paid claim costs of $37,477.08 so far, ORS 656.580, and reasonably expects to pay future expenses of $23,386.39 attributable to the injury.

Claimant filed a third party action against Davcol, Inc., her employer, ORS 656.578, and McKay, the manager of its tavern where claimant had worked, alleging claims for negligence, wrongful discharge, intentional infliction of emotional distress, defamation and retaliatory discharge, and sought total damages of $550,000, of which $200,000 was

[1] Because the third party case was settled rather than brought to judgment, SAIF has no "lien" as the term is used in ORS 656.580. *See Estate of Troy Vance v. Williams*, 84 Or App 616, 734 P2d 1372 (1987). However, SAIF's "just and proper" distribution under ORS 656.543(3) is determined by what its lien on a judgment for damages would have been.

alleged to be damages resulting from negligence that caused the compensable injury.

Davcol and McKay and claimant settled the entire action for $100,000. The settlement agreement recited:

> "1. Plaintiff brought suit against Defendants in the Circuit Court for Multnomah County, Oregon, entitled *Robertson v. McKay, et al.*, Civil No. A8609-05668.
>
> "2. The Defendants have nominal assets saving and except a policy of insurance through Ranger Insurance Company, Policy No. SMP 32 45 32 which covers certain of the claims asserted by Plaintiff in her complaint, namely the wrongful constructive termination and defamation claims only. That policy excludes coverage for claims concerning which benefits are payable or are required to be provided under the workers' compensation laws.

> "3. The parties wish by this settlement agreement to resolve all of the issues between them by applying the proceeds of the policy of insurance referenced above to settle the covered claims between the parties, that is, the wrongful termination and defamation claims to compensate her solely and exclusively for the emotional trauma and distress which was allegedly suffered by her following the end of her period of employment with Defendants.
>
> "4. The parties agree and acknowledge that the claims for which the policy proceeds are available are not compensable under the workers' compensation laws."

Claimant also agreed to satisfy "third party" liens and to apply up to $5,000 of the proceeds "to fund an agreement between the Workers' Compensation Department and defendants to release the lien of that department against defendants in exchange for that amount." The settlement was conditioned on SAIF's approval.

SAIF approved the settlement "with the understanding that the settlement of the third party claim shall not be effective until such time as SAIF receives its share of the settlement proceeds." As it states in its brief, it approved the settlement on the condition that the portion of the proceeds attributable to SAIF's alleged third party lien be held in trust pending resolution of claimant's contention that the lien did not attach to any part of the settlement. SAIF then petitioned the Board to determine its "just and proper" distribution. The Board held that SAIF's lien applies to the proceeds of any and all damages recovered, regardless of the agreed upon composition of the settlement.

Claimant contends that the settlement proceeds were intended, as the settlement agreement expressly provides, to compensate her only for the emotional trauma and distress that she allegedly suffered as result of the wrongful termination and the defamation claims and not for the negligence claim that related to the compensable injury. It is not disputed that employer's insurer was not liable for the negligence claim, because of the policy's exclusion.

SAIF concedes that whatever right to the proceeds it may have is only against any portion of the award attributable

to the negligence cause of action. ORS 656.580(2).[2] It argues, however, that, because "[c]laimant presented no evidence or argument to the [Board] sufficient to enable it to determine what part of the settlement was attributable to her negligence claim" and did not "clearly apportion the recovery between the third party cause of action and the other causes of action," its lien attaches to "proceeds of any damages recovered" or, in this case, to the entire settlement. ORS 656.593(1).

Contrary to SAIF's contention, the settlement agreement clearly apportioned the proceeds between the third party claim and the other claims. It allocated no portion to the claim related to the compensable injury. ORS 656.587 provides:

> "Any compromise by the worker or other beneficiaries or the legal representative of the deceased worker of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board. ORS 656.236 does not apply to compromises and settlements under ORS 656.578 to 656.595."

If SAIF had wished to disapprove of the settlement because nothing was paid to settle the negligence claim, it could have done so. Then claimant would have been required to seek the Board's approval, ORS 656.587, without which the settlement would be void. However, when SAIF approved it, the settlement was validated, even though there remained the need to resolve the issue whether SAIF was entitled to a share of the proceeds pursuant to ORS 656.593(3). By putting the dispute in that posture, SAIF was asking the Board to make that determination and thereby assumed the burden of establishing the portion of the settlement proceeds to which its lien attached. As it concedes, it is entitled to a lien only on proceeds paid to settle the negligence claim. The settlement agreement states expressly that no part of the settlement was attributable to that claim,[3] and there is nothing in this record to show otherwise.[4] Therefore, SAIF is entitled to no share of the proceeds.

Reversed and remanded with instructions to make a distribution order to claimant.

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[2] ORS 656.580(2) provides:

> "The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

[3] That is not to say that a claimant who files a third party claim that includes other claims that are not compensable under the Workers' Compensation Act may avoid the paying agent's lien merely by allocating all, or substantially all, of the settlement proceeds to claims against which the paying agent has no lien. Here, the two claims to which the settlement proceeds were applied, if established, could easily have resulted in a damage award in the amount paid, and there was no insurance covering the negligence claim.

[4] For example, SAIF made no effort to determine whether Davcol or McKay paid anything from their own funds. If they had, one might reasonably infer that the payment was made to settle the negligence claim, for which Davcol was not insured; limits of liability under the insurance for the other claims was more than adequate to cover what was paid on those claims. If, in fact, the insurer paid the entire $100,000 and if neither Davcol nor McKay was able to respond in damages, as the settlement agreement suggests, the settlement agreement was not a sham to avoid SAIF's lien. SAIF advances no explanation as to why the insurer would have paid anything on an uninsured claim, and there is no evidence that even suggests that it would or did.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Raymond R. Bird, Claimant.

LIBERTY NORTHWEST INSURANCE
CORPORATION et al,
Petitioners,

v.

BIRD,
Respondent.

(87-16838; CA A60337)

Appeal from Workers' Compensation Board.

Argued and submitted October 9, 1989.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.

Darris K. Rowell, Salem, filed the brief for respondent. With him on the brief was Olson, Rowell & Walsh, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded.

WARREN, J.

Employer seeks review of an order of the Workers' Compensation Board setting aside the insurer's denial of medical benefits and determining that claimant's request for surgery was not barred by *res judicata.* We reverse and remand.

Claimant injured his thumb and wrist at work in 1986. Liberty Northwest accepted the claim. Later, several doctors examined claimant and made varying diagnoses. Dr. Ellison diagnosed left trigger thumb and carpal tunnel syndrome and requested authorization for surgery. Liberty Northwest denied authorization for surgery on February 17, 1987, stating that it was not reasonable and necessary and that claimant's condition resulted from an unrelated psychological condition. Claimant requested a hearing. On May 26, 1987, Liberty Northwest refused a second request for medical benefits, stating that the treatment did not result from the accepted injury. Claimant again requested a hearing, and the cases were consolidated. However, claimant withdrew his requests for hearings on both refusals, and the referee dismissed the case on August 6, 1987.

Later, in August, 1987, Dr. Lafrance, a neurologist, performed nerve conduction studies that confirmed the diagnosis of left trigger thumb and carpal tunnel syndrome. He referred claimant to Dr. Henshaw, an orthopedic surgeon, who requested authorization for surgery.

Liberty Northwest refused the authorization on October 12, 1987. This time it stated that claimant's conditions did not result from his employment or from his accepted injury. Claimant requested a hearing, and the referee held that he was barred by *res judicata*. The Board reversed. It held that each new request for prospective medical services is a distinct claim and that, therefore, claimant's request was not barred by *res judicata*. It also found that the record had been fully developed and that it could decide the merits of the medical benefit request. It held that claimant's condition resulted from the compensable injury but did not make a separate determination that the condition had changed since the February 17, 1987, benefit refusal.

Under ORS 656.245, an insurer must pay a claimant's reasonable and necessary medical expenses for conditions

resulting from a compensable injury. That duty continues throughout the claimant's life and is not dependent on a showing of aggravation. *Wait v. Montgomery Ward, Inc.*, 10 Or App 333, 499 P2d 1340, *rev den* (1972). Employer contends that, notwithstanding that rule, the unappealed February 17 refusal of the request for authorization of surgery precludes consideration of the present request.

In workers' compensation cases, when a claim for medical services is reasserted after being once denied, the question is whether the claimant's condition has changed so as to have created a new set of operative facts that previously could not have been litigated. *See Argonaut Ins. Co. v. Rush*, 98 Or App 730, 780 P2d 748 (1989); *Kepford v. Weyerhaeuser*, 77 Or App 363, 713 P2d 625, *rev den* 300 Or 722 (1986).

In *Million v. SAIF*, 45 Or App 1097, 610 P2d 285, *rev den* 289 Or 337 (1980), the claimant was injured at work in 1972, and SAIF accepted the injury. In 1975, she had surgery on her shoulder. Her claim for compensation for the surgery was denied because of insufficient evidence connecting her shoulder condition to the 1972 injury. In 1978, she again sought compensation for the 1975 surgery, this time arguing that her condition was caused by her work activities from 1973 to 1975. We held that the initial denial precluded consideration of the 1978 claim, because claimant could have presented that evidence at the time of the first hearing.

Like *Million*, the present case involves one injury and two requests for surgery. Employer denied authorization for surgery that Ellison requested for claimant's left trigger thumb and carpal tunnel syndrome. In the same year, claimant again sought authorization for surgery requested by Henshaw, apparently for the same conditions. The Board's opinion does not explain why the later request is any different from the earlier one, other than the difference in doctors, or why the later request could not have been asserted at the same time as the earlier one.

The Board held that claim preclusion is not a bar, because the surgery for which payment is sought has not been performed yet. That fact does not take this case outside the rule of *Million v. SAIF, supra*. Whether the treatment has been performed or not, the claimant has one opportunity to prove that a particular treatment for a particular condition is

reasonable and necessary and is related to a particular compensable injury. ORS 656.245. A claimant is not entitled to relitigate the issue just because he finds new evidence in support of his claim.

Although a claimant may be barred from presenting new evidence relating to the same condition, he may renew a request for medical services if his condition has changed *and* the request is supported by new facts that could not have been presented earlier. *See Argonaut Ins. Co. v. Rush, supra,* 98 Or App at 735; *Kepford v. Weyerhaeuser, supra,* 77 Or App at 365. In this case, the Board did not determine whether claimant's condition for which he seeks treatment had changed since the earlier request. Unless it has, the claim is barred. Whether claimant has presented evidence of a change in his condition in support of his renewed request for treatment is for the Board to decide; accordingly, we remand to the Board for a determination of that question.

Reversed and remanded.

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A list of Unpublished Orders has been omitted from this quarter's index, owing to space considerations. Unpublished Orders are those that are judged to be of no precedental value, including Memorandum Opinions and routine Own Motion Orders. The previous quarter's index includes a list up through the end of September. If you would like a complete list of the Unpublished Orders for 1989, please call or write VAN NATTA'S (1017 Parkway Drive NW, Salem, OR 97304, 503-362-7336). If you have a question concerning a particular Order or Orders, please call.

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Smith, Cecil B. (87-04162)-------2147
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Smith, Delbert W. (86-15272)-------2319
Smith, Eillene J. (86-03224)-------131
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Speight, Roy E. (89-06178 & 88-17191)-------2215
Stafford, Robert (87-16630)----------2339
Stahlman, Jim (88-14976)-------2005
Stanley, Jane E. (WCB 86-11196; CA A49399)-------1556
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Storey, Nancy V. (87-01651)-----1951
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Stowell-King, Debra L. (87-18325 & 87-13263)-------2408
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Stride, Pete M. (86-12109)-------1089
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Swartwout, Sara I. (88-0426M)-------1471,2437
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Taisacan, Vicente M. (87-03602)-------1005
Talley, Stanley W. (87-11371 & 87-16102)----------2395
Tankersley, Bobby P. (87-16562)-------2245
Tate, James D. (86-18044)-------2247,2414
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Trachsel, Herbert K. (87-03027 & 87-03026)--------1734
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